Submission No 148

INQUIRY INTO AMBULANCE VICTORIA

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Parliament of Victoria
Legislative Council Legal
and Social Issues Committee

Excellence Under Pressure:

Observations and recommendations on the operations of Ambulance Victoria

February 2025

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About the author

1. The author of this submission is Adjunct Associate Professor Ray Bange OAM. Professor Bange is an independent researcher and experienced health policy advisor. An Executive Committee member of the Australian Health Care Reform Alliance, he has contributed to the work of the Services for Australian Rural and Remote Allied Health, and the National Rural Health Alliance.
2. Professor Bange holds an adjunct professorial appointment from Central Queensland University and is the recipient of an Order of Australia Medal awarded for contributions to paramedicine, education, and the community. He is an Honorary Fellow of the Australasian College of Paramedicine and the Australian Institute of Paramedic Practitioners.
3. His concern for the ambulance service sector and its integration into the health and care system is built on extensive involvement with health policy development and long association with patients and professional practice, education, accreditation, and regulation across all Australian jurisdictions including Victoria.
4. This submission is made in a personal capacity and deals principally with higher-level policy matters rather than individual cases or issues which are considered operational. The author grants consent to publish with the author's name but without other contact details.

An overview

5. The Terms of Reference (ToR) for this Inquiry are outlined in *Appendix A*. Notwithstanding their broad scope that make specific reference to ambulance ramping and the management and functions of Ambulance Victoria (AV), the author has interpreted the Inquiry objectives from a fundamental viewpoint; that public policy should deliver efficient and high-quality health services to all Victorians served by AV across all stages of life.
6. Ambulance services are often the first points of access to care for those experiencing an acute or life-threatening health concern. Although not recognised directly for funding by the Commonwealth, they are widely used in their dual capacity for public health management and social health safety net for those unable to access other care in times of need.
7. Ambulance ramping and response times have dominated the news about the health system, with significant media coverage and parliamentary debate.[1] Ramping has been a topic of increasing public concern with several inquiries into ambulance service operations across Australia during the past decade. In 2021 these concerns resulted in the presentation to the South Australian parliament of a petition (No.84 of 2021) containing more than 44,000 signatures and calling for more ambulance resourcing.
8. However, stand-alone measures focused solely on AV will not solve dangerous overcrowding in Emergency Departments (EDs) or fix deeper problems in community healthcare delivery. Concentrating on AV may not fully tackle the downstream causes of delays in patient assessment and treatment, which could stem from gaps or inefficiencies in other parts of the health system.
9. To address the issue of ED overcrowding, which leads to ambulance delays (ramping) and risks harm to patients, their families, and healthcare workers, a comprehensive, system-wide approach is necessary. This includes supporting paramedics and other staff at the core of AV operations, who are subject to immense work pressures and emotional stress.
10. The current Inquiry is being conducted in the aftermath of the COVID-19 pandemic with impending changes in health service delivery models, the introduction of new technology including Generative Artificial Intelligence (AI) and wide-ranging policy developments at both local and national levels, including the National Primary Health Care 10 Year Plan.

[1] *Ambulance ramping at Maroondah Hospital forces paramedics to call for back-up to treat patient*, ABC News, 28 August 2024, https://tinyurl.com/4uumthvv Accessed 24/02/2025

Sustainable community healthcare

11. At a macro scale, governments are responsible for ensuring community health outcomes involving more than advanced medical interventions. These health outcomes are influenced by economic and social policies as well as preventive and primary care.
12. There is widespread acceptance that the health of the community is strongly impacted by policies spanning the social and economic environments, commonly referred to as the Social Determinants of Health (SDOH).[2] The influence of the SDOH on longer-term emotional and physical health has been well established by Marmot and other researchers.[3]
13. Achieving a sustainable health system requires consideration of climate change as a determinant of health from both direct and indirect impacts. It is potentially one of the greatest threats to human health and wellbeing, since the long-term effects of global warming will exacerbate inequities in health outcomes.[4]
14. These factors underpinned the Sustainable Health Review by the Western Australian Government[5] which developed eight enduring strategies and 30 recommendations, seeking to drive a cultural shift from a predominantly reactive, acute, hospital-based system – to one with a strong focus on prevention, equity, early child health, end-of-life care, and seamless access to services at home and in the community.
15. The COVID-19 pandemic brought the issues of access and equity into sharp focus. Measures such as lockdowns, social distancing and cancellations of routine care significantly impacted those already facing problems with access and inequality.[6]
16. The staffing situations experienced during the pandemic drew attention to the importance of public health, the need for stability and growth in funding and the importance of depth and diversity of infrastructure, including the availability and deployment of human resources.
17. Long-term sustainability must acknowledge that the health system extends beyond EDs and hospitals and advanced medical interventions - and that the operations of AV are strongly interdependent with primary care and a range of other health and social care services such as mental health, aged care and palliative care.
18. The author suggests that as part of the response to the present Inquiry, the Victorian Government endorses a commitment to a *'Health in All Policies'* approach that identifies how decisions across all major policy areas affect health, and in turn, how improved health can support the goals of those sectors.
19. The Commonwealth's 10-Year National Primary Health Care Plan is intended to guide future primary health care, as part of the Government's Long-Term National Health Plan. Under that Plan, the Australian Government is committed to implementing a health system that is more person-centred, integrated, efficient and equitable at local and regional levels.
20. While those high-level national policy goals are laudable objectives, their execution will depend not only on facilities and infrastructure but also on the availability of adequate health workforces and innovative ways of service delivery. Victoria and its public health services including AV will be key partners in this endeavour.[7]

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[2] Social Determinants of Health - the social and economic factors and conditions in which people are born, grow, live, work, and age, that are known to be the most powerful determinants of population health. World Health Organisation, https://bit.ly/3eUnNyF Accessed 25/02/2025.

[3] Sir Michael Marmot, *Fair Society, Healthy Lives, The Marmot Review* www.ucl.ac.uk/marmotreview The Marmot Review, February 2010 ISBN 978–0–9564870–0–1 https://bit.ly/2z8U5PS Accessed 25/02/2025.

[4] Bange R, *Lancet Countdown on health and climate change,* AHCRA, Facebook, 24 October 2021. https://bit.ly/33GLKHv Accessed 25/02/2025.

[5] Sustainable Health Review. (2019). *Sustainable Health Review: Final Report to the Western Australian Government,* Department of Health, Western Australia. https://tinyurl.com/ej6v63vh Accessed 25/02/2025.

[6] Oxfam, *Inequality Kills*, Oxfam International, January 2022, ISBN 978-1-78748-846-5, https://tinyurl.com/yckyc564 DOI: 10.21201/2022.8465 Accessed 25/02/2025.

[7] Hon Mark Butler MP, Government building Australia's future with more money for public hospital reform, Department of Health and Aged Care, 6 February 2025. https://tinyurl.com/2d97m7zm Accessed 27/02/2025.

21. The innovations needed may include regulatory reform and flexible funding models for a range of telehealth and primary health care services, covering medical practitioners, nursing and Allied Health Practitioners (AHPs), and better support for mental health, chronic disease and rural and remote communities.
22. Given the limited time to undertake a forensic examination of the Victorian health system, and noting the devolved governance arrangements, this submission focuses on the capacity of paramedic services and paramedics to address these community needs – it highlights key workforce issues and the importance of integrating and coordinating services across the whole health and care system.
23. It highlights the capacity of paramedics to work independently or in multidisciplinary teams in public and private practices in addition to AV and suggests ways to mobilise paramedicine and other AHPs in delivering optimal care.
24. Paramedicine does not stand alone, and there is irrefutable evidence demonstrating the benefits of AHPs in improving patient outcomes, minimising risk and harm from illness and improving the health system's capacity to meet increased demand.
25. Allied Health, Medicine and Nursing/Midwifery are currently recognised as the three fundamental pillars of the patient care workforce, with each contributing specific skills to deliver patient-centred care. However, despite being a significant proportion of the health workforce, AHPs have been underutilised in contributing to improved health outcomes.
26. The Australian healthcare system has been slow to harness their full potential at a system level, leaving many opportunities untapped in addressing access and equity challenges. Our current health model has been focused on acute, episodic care. To meet evolving needs a transformational change is required – one that integrates and makes full use of all three pillars of the health workforce.
27. The Australian Minister for Health and Aged Care the Hon Mark Butler MP envisages that optimising the use of Australia's health workforce will improve health access and equity across all communities – including regional, rural, and remote areas.
28. This objective has seen the establishment of the *Strengthening Medicare Taskforce* to identify high priority reforms in primary care, and the subsequent *Unleashing the Potential of our Health Workforce Review* – which has examined how all health practitioners can be helped to work to the full extent of their skills and training.[8]
29. The *Unleashing Review* has highlighted the opportunities for mobilising the expertise of AHPs, including paramedics (p 196) who form a cohort of available registered practitioners and are among the most highly trained paramedics in the world.

Insight 1. Australia lags behind comparable advanced economies (e.g. UK, Canada, NZ) in the strategic use of AHPs and paramedics in primary care and other care roles.

Insight 2. There is a surprising lack of understanding of the education and skillsets of contemporary AHPs and registered paramedics on the part of many health professionals, policy advisors and workforce planners.

Insight 3. Australian paramedics are registered health professionals and among the most highly qualified paramedics in the world, with an outstanding research and publication record.

[8] Department of Health and Aged Care, *Unleashing the potential of our workforce - Scope of Practice Review Final Report,* Australian Government, Canberra, October 2024. https://tinyurl.com/bdfj8w28 Accessed 27/02/2025.

The ramping conundrum

30. The eight Australian public ambulance services are among the world's best, operating as jurisdictional community services that cater for patients in times of need regardless of their age, gender, ethnicity, or economic status. AV is recognised globally for its innovation, research and quality of care. Nonetheless, the operations of AV are open to scrutiny and subject to comment as outlined in *Appendix B*.

31. Ambulance services are a vital part of Australia's health system, even though they are often overlooked or absent from health policy considerations at the national level.[9, 10] They are a unique public outreach health service whose role has evolved well beyond the simple patient transport function of fifty years ago.

32. Ambulance ramping is the visible and widely reported manifestation of access block at the ambulance-hospital interface. The Australasian College for Emergency Medicine (ACEM) has outlined a model of ED operation showing the complexity of patient flow *(Figure 1).*

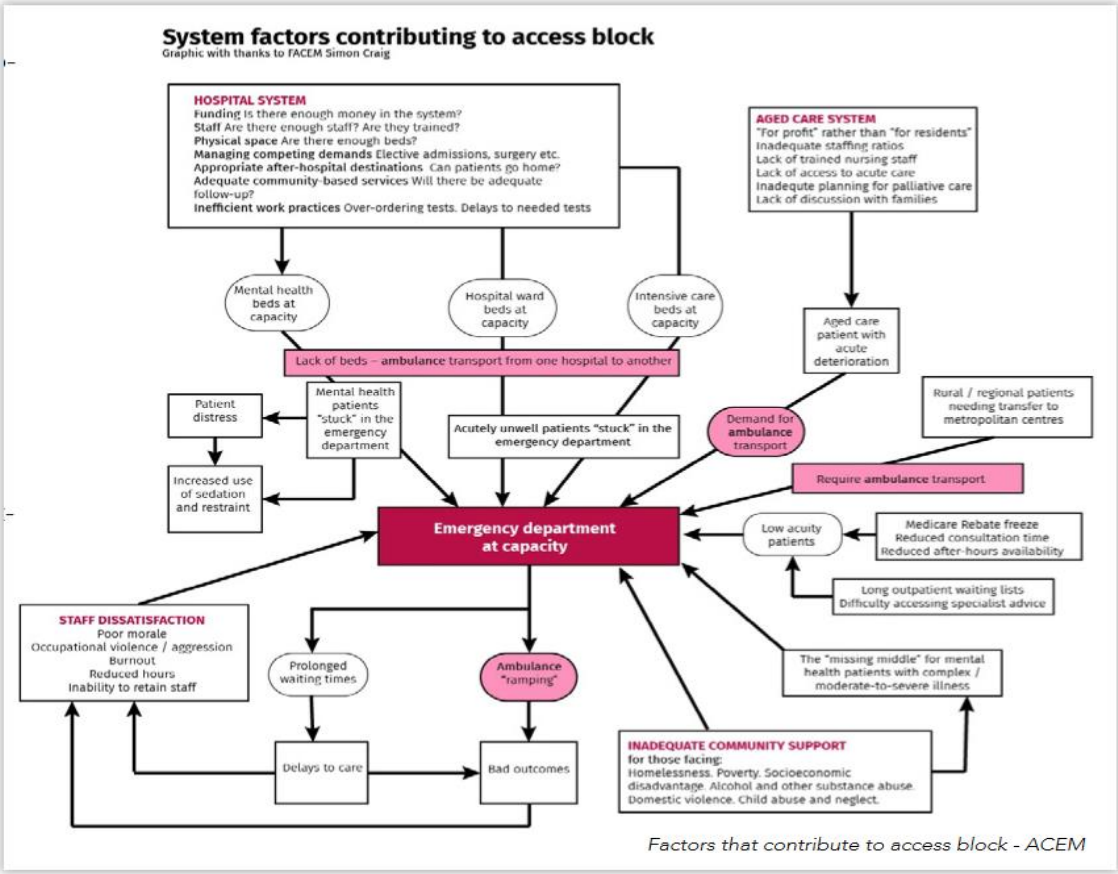

Figure 1. ACEM Model of Access Block

33. The capacity of the ED can be overwhelmed by excessive (front-end) demand or a lack of hospital beds which flows back to the ED. This blockage is then reflected in ambulance ramping that takes ambulance resources and paramedics out of effective service.

34. The traditional model of hospital triage and ED operations may no longer be fit for purpose. Triage in various forms and at different stages of the patient journey may stream patients according to need or infection risk, and in some cases redirect appropriate patients to other services. The pandemic has shown how ED infrastructure needs to be modified to improve safety with the separation of patients, individual rooms, and airborne infection control.

[9] Bange R, *Final report of National Rural Health Commissioner*, The Paramedic Observer, Facebook, 17 July 2020. https://tinyurl.com/2rud4ymu accessed 26/02/2025

[10] Bange R, *National Rural Health Commissioner Interim Report,* The Paramedic Observer, Facebook, 1 April 2020. https://tinyurl.com/akh4cf6c accessed 26/02/2025

35. Front-of-house process redesign may include direct-to-team referral models (clinic or ward) and bypass the ED trauma centre. Recent years have seen the implementation of virtual care and Hospital in the Home models.

36. Optimising patient flow is a key factor and extended hours clinical services can facilitate hospital discharge (freeing up beds) while a minor injuries unit, linked to the ED for walk-in, booked, new and follow-up patients may assist throughput.

37. The important role of Patient Transport Services or Non-Emergency Patient Transport (NEPT) should not be overlooked. With paramedicine an independently registered health profession, the recognition of private patient transport and paramedic service providers needs to be resolved, along with their accreditation and potential use as a surge resource.

38. A simplified conceptual framework of the patient journey and its involvement with key aspects of care is shown below *(Figure 2)*.

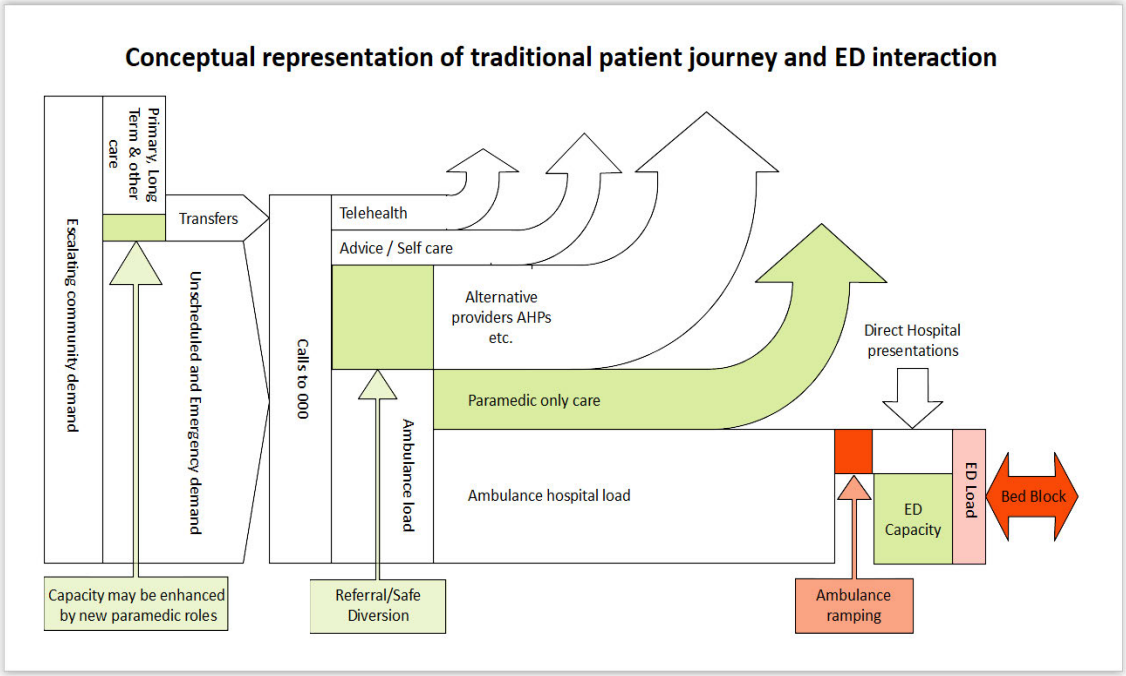

Figure 2. Model of Emergency Department interactions (Bange)

39. Figure 2 shows how paramedics may enhance service capacity across the spectrum of health, ranging from primary care to the ED and hospital environment. This care may include chronic conditions and long-term/senior and palliative care (external services not shown).

40. This submission places a focus on:

    a) A brief assessment of AV capacity and the paramedicine workforce;

    b) Mitigation of demand through better primary and community care with the use of paramedics;

    c) Measures to minimise transport via alternative pathways of care;

    d) Ways in which workforce resources can be enhanced by mobilising paramedicine, e.g., in hospital EDs and other settings; and,

    e) The impact of governance and other selected issues from the Terms of Reference.

Ambulance Victoria: a multifunctional health service

41. AV employs medical practitioners, nurses, AHPs and paramedics, who are noted for their capacity to work in unstructured out-of-hospital situations. Many of these paramedics hold additional specialised training or qualifications in various aspects of trauma care, mental health, palliative care and other areas of practice related to primary care.

42. AV paramedics are often the first responders to provide medical care within the community, monitoring and assessing patients; treating injuries and illnesses; stabilising patients; and transporting them to hospitals or other medical facilities if necessary.

43. Contrary to popular belief, personnel working for AV are engaged in providing a wide variety of health and care services across community health and care settings in addition to applying their expertise in emergency response, trauma care and resuscitation.

44. These services are crucial in rural and remote areas where other medical services are limited. They reduce the number of ED presentations, thereby reducing the likelihood of ramping and increasing the availability of resources to provide more timely responses.

45. Examination of AV responses from the Report on Government Services (ROGS)[11] shows there has been consistent growth in the total number of responses annually. Of significance is that 60% or more of the annual responses are not emergency but are urgent or non-emergency care more aligned with primary and community care *(Figure 3).* This pattern of increasing non-emergency response is common across all Australian jurisdictions, with a national emergency response rate of 45.4% in 2024.

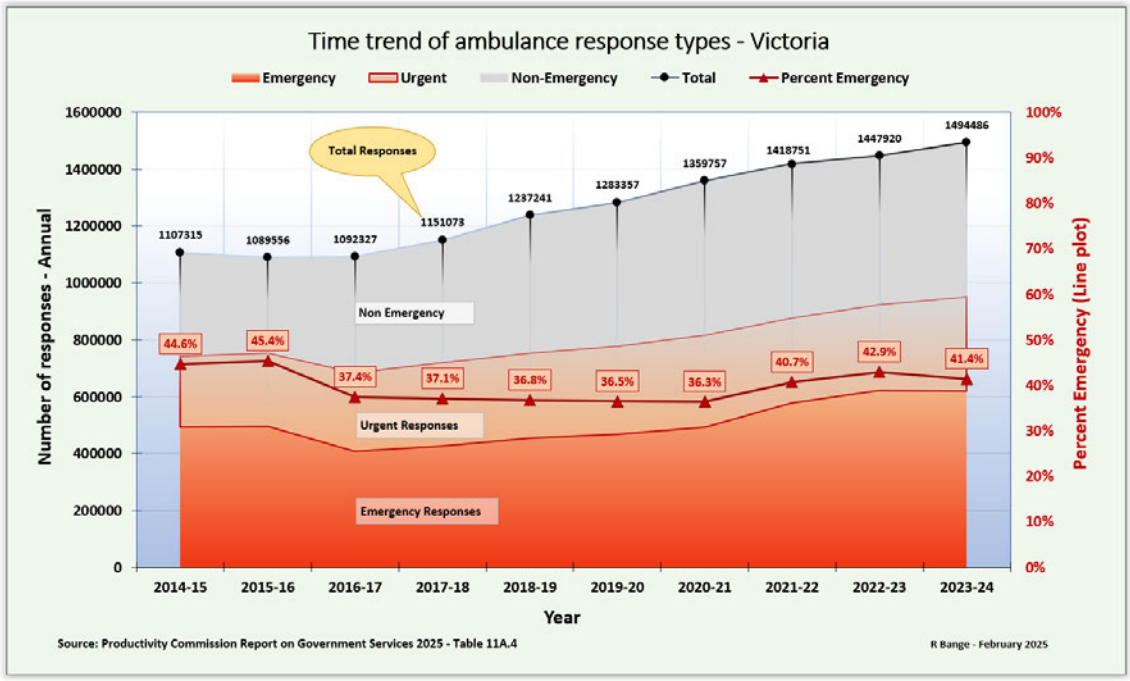

Figure 3. Time Trend of Ambulance Victoria Responses

46. The broader role of ambulance services in providing mobile and emergency care in improving population health is increasingly being acknowledged in strategic development plans including AV.[12] In February 2017, the UK Association of Ambulance Chief Executives launched a joint consensus statement committing NHS ambulance trusts to increased collaboration across the NHS in supporting improved health and wellbeing.[13]

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[11] Australian Government, *Report on Government Services 2025: Part E Section 11, Ambulance Services,* Productivity Commission, 6 February 2025. https://tinyurl.com/46b9vru5 Accessed 25/02/2025.

[12] Ambulance Victoria, *Strategic Plan 2023-2028*, Doncaster, Victoria. https://tinyurl.com/yc7kkt8z Accessed 26/02/2025.

[13] Association of Ambulance Chief Executives, *Working together with ambulance services to improve public health and wellbeing*, Consensus Statement, 7 February 2017. https://bit.ly/3v3mraJ Accessed 15/02/2025.

47. An example of this wider community health role is the care of patients as close to their homes as possible. Welsh Ambulance paramedics now may administer a greater range of medicines and manage more patients with complex care needs.

48. Innovative response models are being explored in Australia, and the Victorian government has passed legislation to facilitate the prescribing of medications by appropriately qualified paramedics.[14] The implementation and benefits of these changes including the Victorian Virtual Emergency Department (VVED) remain to be fully evaluated, but initial outcomes have proved highly promising.[15]

49. The AV experience with paramedic treatment to reduce patient conveyances and ED load and ramping can be seen in the ROGS data for patient treatment on the scene *(Figure 4).* This alternate pathway using appropriately qualified and experienced paramedics has been growing and resulted in 15.4% of patients not needing to be transported to hospital EDs in 2024. Other Australian ambulance services are also expanding treatment on the scene to cope with an increasing workload.

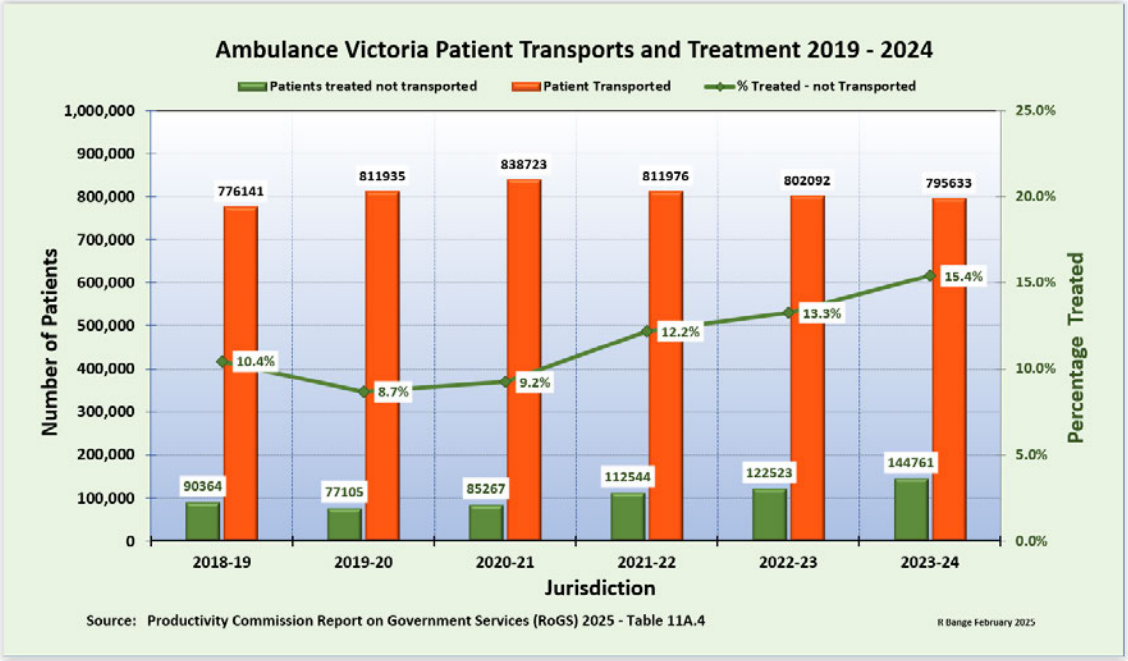

Figure 4. Time Trend of Ambulance Victoria Treatment and Transport

Insight 4. Australia has an established network of world-leading paramedic (aka ambulance) services organised on a jurisdictional basis and supported by robust governance, logistical and communication structures.

Insight 5. Ambulance Victoria (AV) provides healthcare services across the community for much more than transport and emergency response.

Insight 6. The provision of community healthcare beyond emergency response underlines why the ambulance sector should be funded in part or whole by the Commonwealth, and why representation of paramedicine is needed at a policy level.

[14] Bange R, *Victorian paramedicine legislation*, The Paramedic Observer, Facebook, 3 February 2025. https://tinyurl.com/yc6dyscz Accessed 25/02/2025.

[15] Premier of Victoria, Victorians Continuing To Get World Class Care, Victorian Government Media Release, 6 November 2024. https://tinyurl.com/y8whu6b6 Accessed 27/02/2025.

Ambulance Victoria snapshot

50. AV provides mobile medical services 24 hours a day, 365 days a year, delivering clinical care in diverse conditions under varying workloads and time constraints. Its operations require a mixture of high-level clinical and management expertise to navigate complex logistical challenges in often distressing circumstances. What are some key measures?

Funding

51. AV revenue comes through state government grants, transport fees, subscriptions, and other income. The aggregated figures are reported in ROGS for comparison purposes, while the AV Annual Reports provide more detailed financial information.
52. There was continued growth in AV revenue from 2015 until 2022-23, with government grants ranging from about 65% to 79% of total revenue and only minor variations in transportation fees and subscriptions and other income *(Figure 5).*
53. Overall revenue declined by $209.6 million from $1,692.2 million in 2022-23 to $1482.6 million in 2023-24 along with government grants that fell from $1,333.7 million (78.8%) to $1151.7 million (77.7%) of total revenue.
54. Expenditure has exceeded revenue but also declined from $1,758.2 million in 2022-23 to $1,561.7 million in 2023-24 (ROGS Table 11A.11). The revenue shortfall is deeply concerning and indicates an organisation under extreme pressure with reorganisation, job cuts and program cessation, affecting the quality and availability of services.

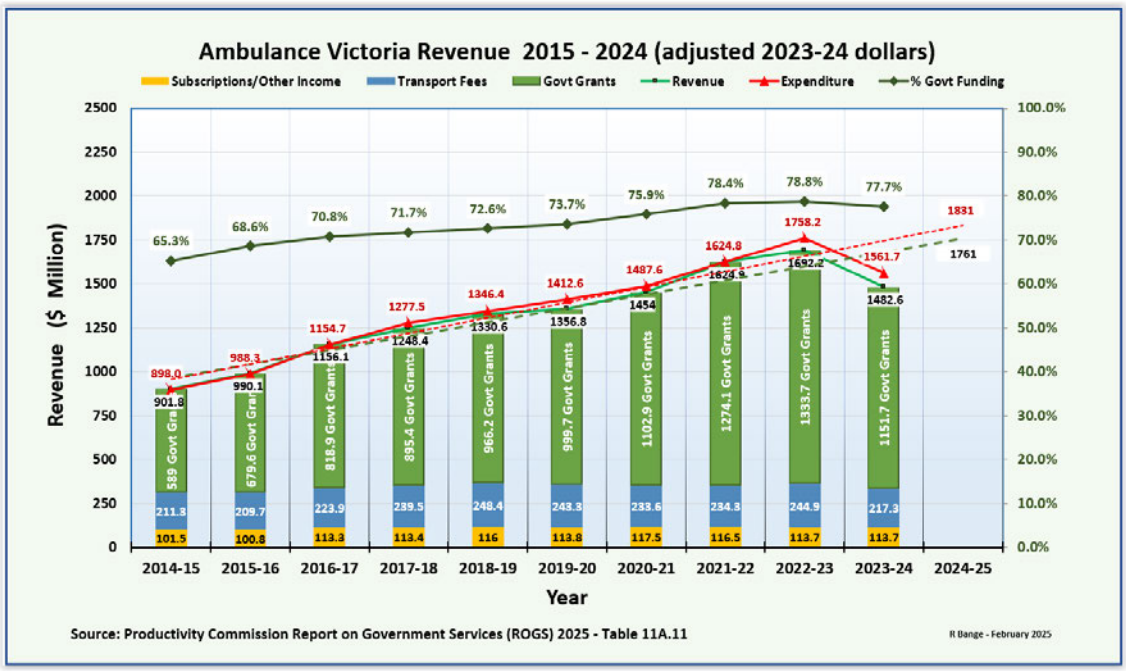

Figure 5. Time Trend of Ambulance Victoria Revenue

55. On a per capita basis, AV total revenue has grown from $151.37 per person in 2014-15 to a peak of $252.41 in 2022-23 and dropped back to $214.69 in 2023-24. This compares with a national average revenue for ambulance services of $209.27 per person for 2023-24.
56. Transport fees are AV's largest non-government source of revenue, and were impacted by protracted industrial action that saw the income drop from $244.9 million in 2022-23 to $217.3 million in 2023-24.
57. As a service that responds to all 000 requests (with or without attendance and transport) there is limited logic in maintaining funding arrangements that are not universal and engage internal and external resources in billing and recovery activities.

58. For certainty and efficiency, consideration should be given to adopting a single stream of government funding from general revenue, partly or fully underwritten by the Commonwealth and/or a more general levy that reflects the broader care services *(para 45)* and potential user base. This approach would see the government fully fund the ambulance service and make it nominally 'free' for residents, like in Queensland and Tasmania.

Insight 7. On equity and access grounds, a universal community service that responds to all 000 requests should not be underpinned by users. It should be funded as an essential community service like the police.

Personnel

59. AV operational staff have increased steadily over the past decade along with increasing demand *(Figure 3, para 44).* There has been significant growth in communications staff since 2019-20 driven by the need for enhanced response communications *(Figure 6).*

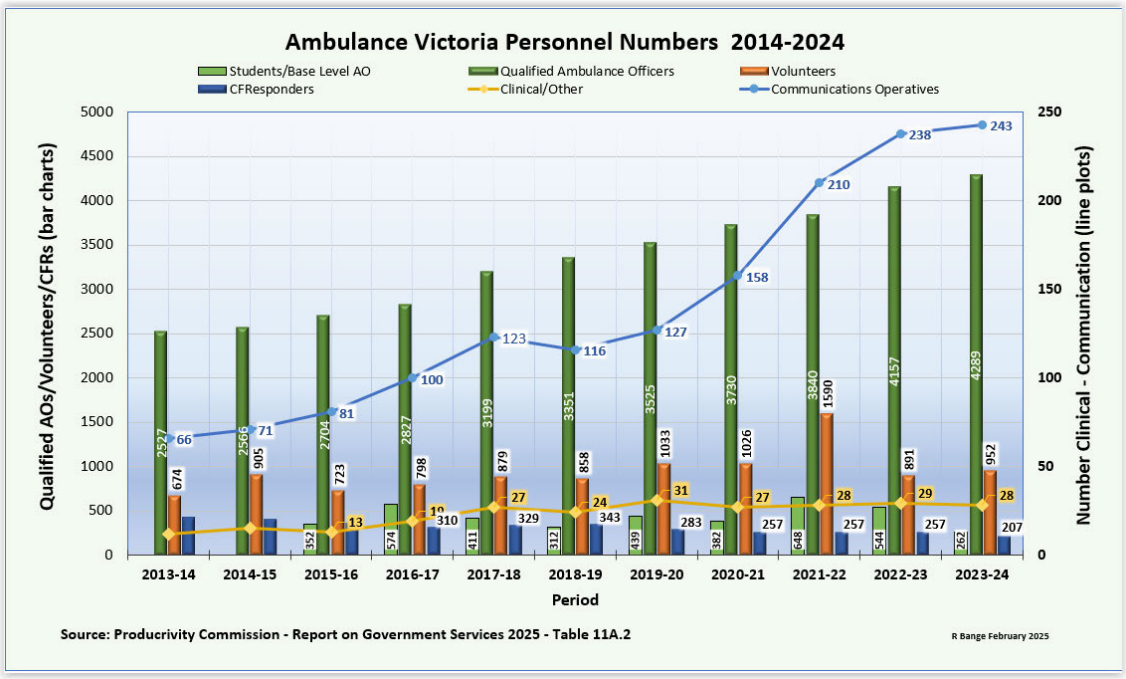

Figure 6. Ambulance Victoria personnel numbers

60. Australia has low ambulance service attrition rates. While the AV rate has shown an uptick since 2019-20, the rate in 2023-24 was only a little above the national average despite independent surveys on Workplace Climate and Wellbeing showing strong intentions to leave *(Figure 7).*[16,17]

61. This increase may have come from several reasons including the impact of the COVID-19 pandemic, delays in resolving the EBA and internal cultural issues which saw the Chief Executive Officer resign in August 2024 after only 18 months in the position.

[16] Holland P, Vieceli J, Thynne L, Tham TL, *Findings from the Survey on Workplace Climate and Well-being of Victorian Ambulance Workers (vol. 1)*, Melbourne: Victorian Ambulance Union; December 2020. https://tinyurl.com/mnu3fdru Accessed 27/02/2025.

[17] Holland P, Vieceli J, Thynne L, Tham TL, Findings from the Survey on Workplace Climate and Well-being of Victorian Ambulance Workers (vol. 2), Melbourne: Victorian Ambulance Union; March 2021. https://tinyurl.com/3cybz36u Accessed 27/02/2025.

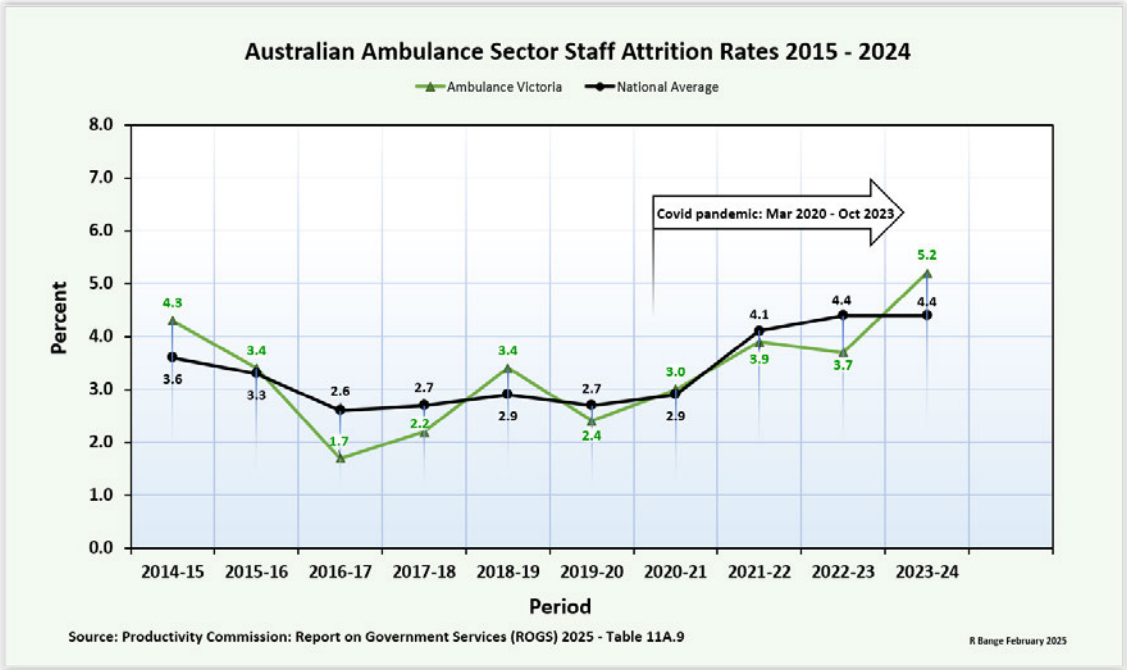

Figure 7. Ambulance Victoria and Australian Attrition Rates

Practitioner supply and sustainability

62. The capacity of AV to respond to widely fluctuating demands depends on the availability of operational staff, with the number of frontline paramedics a key workforce consideration. AV must compete with other Australian services and active recruitment from UK, Canadian and U.S. services, with the London Ambulance Service alone having more than 500 paramedics from Australia and New Zealand.

63. Paramedicine currently has an abundance of registered practitioners and the availability of paramedics to fill positions within AV and other areas of health should not prove difficult. This recruitment would depend on sufficient funding and other logistical constraints. For AV that would entail issues such as placement and infrastructure capabilities (ambulance stations, vehicles, mentors etc.) *(Figure 8).*

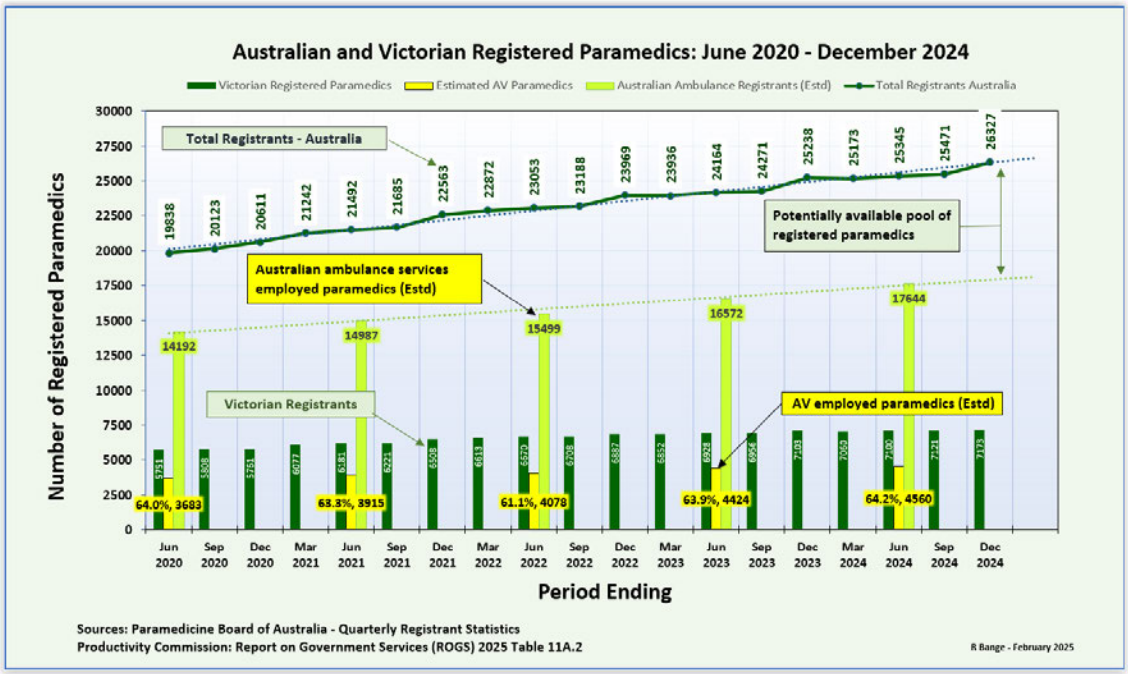

Figure 8. Potential Availability of Registered Paramedics

64. Engagement of additional paramedics depends on adequate transition to practice internship training to ensure safety and quality. Given the AV age profile of operational personnel the retention of experienced paramedics is a high priority *(Figure 9).*

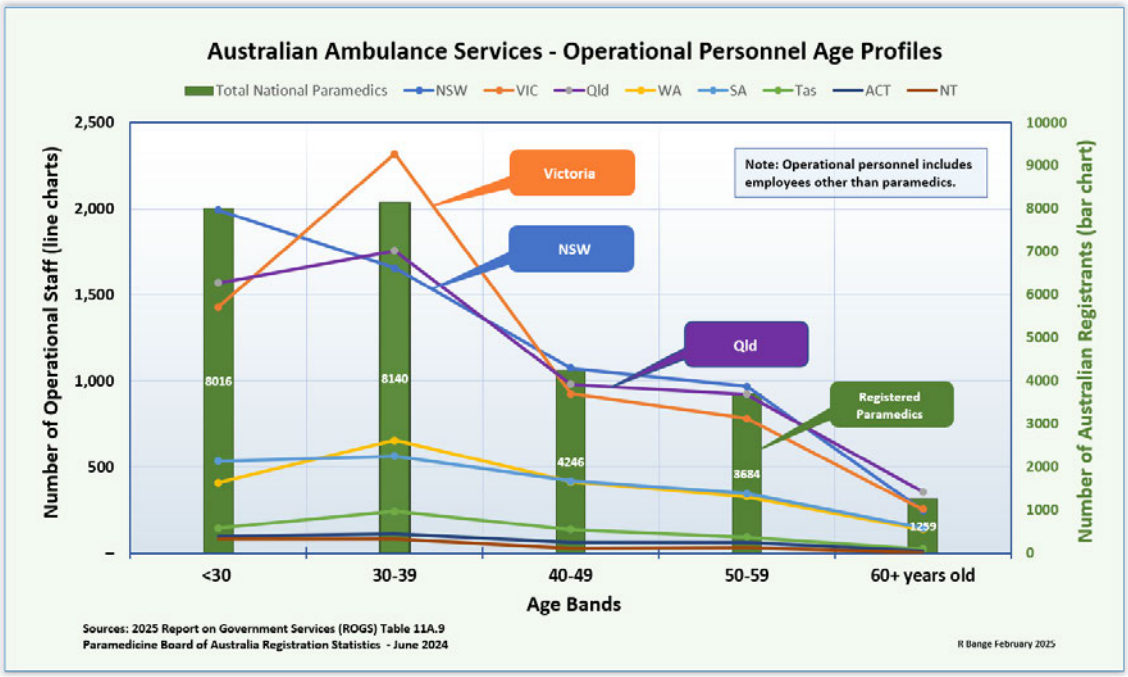

Figure 9. Australian Ambulance Service Age Profiles

Patient satisfaction

65. To evaluate AV patient-facing care, the author has examined the ROGS 2025 patient experience data (Table 11A.8). This shows exceptional levels of satisfaction at direct practitioner level but much less satisfaction with AV timeliness *(Figure 10)*.

66. There are high public expectations relating to response times which in many cases have limited relevance to the efficacy and urgency of care. The capacity to provide timely care depends on available resources - and this is affected by both internal factors (e.g. funding) and external factors like ambulance ramping that reduces service resources and availability.

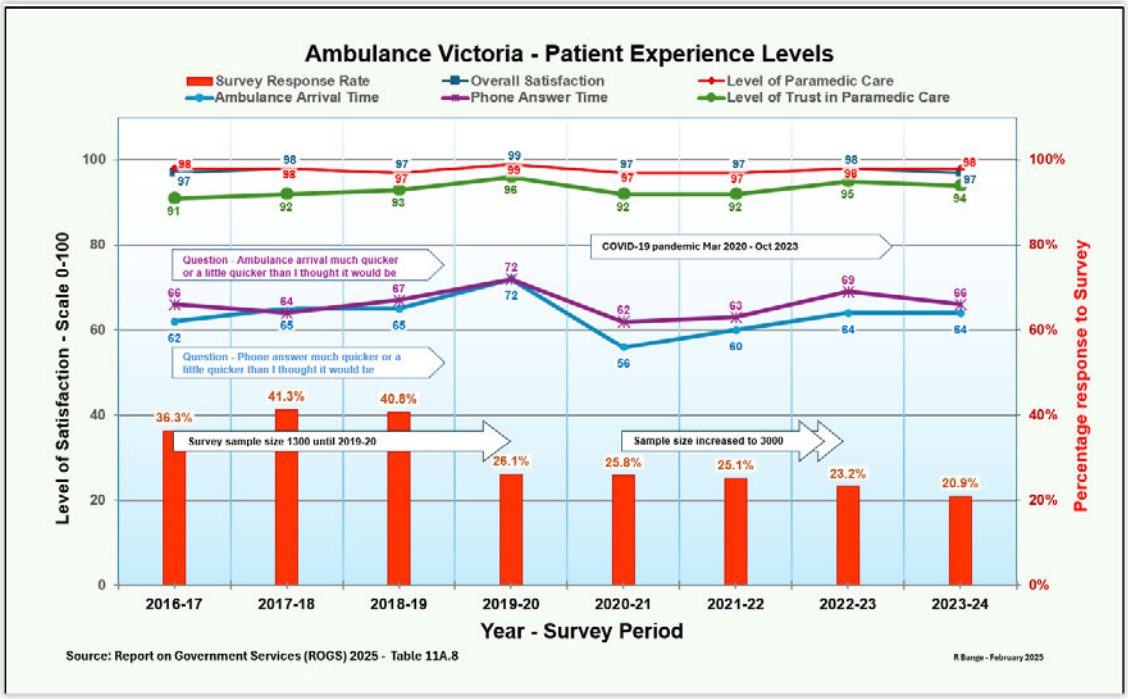

Figure 10. AV Patient Experience Survey Outcomes

Clinical performance

67. Clinical performance covers many aspects and ROGS provides limited data on Pain management and Cardiac arrest survival rates. Victoria shows consistently good comparative outcomes for out-of-hospital cardiac arrests (OHCA) and remains a leading Australian performer - assisted by Automated External Defibrillator-linked communities and GoodSAM emergency response support services.

68. Better cardiac arrest data is available from the annual Victorian Ambulance Cardiac Arrest Registry (VACAR) Reports.[18] VACAR is a quality assurance initiative that captures data on all OHCA attended by emergency medical services in Victoria. The registry commenced in October 1999 and is an important resource for researchers, policymakers and practitioners that is regularly cited internationally *(Figure 11).*

69. VACAR data is used to monitor response intervals, treatment protocols and cardiac arrest patient outcomes. AV clinical and operational data is supplemented with outcome data from Victorian hospitals and the Victorian Registry of Births, Deaths and Marriages.

70. The VACAR is one of the largest pre-hospital cardiac arrest registries in the world and supports a significant research program into the care of cardiac arrest patients. Taken along with other research work and publications, the AV commitment and performance across many clinical areas is outstanding.

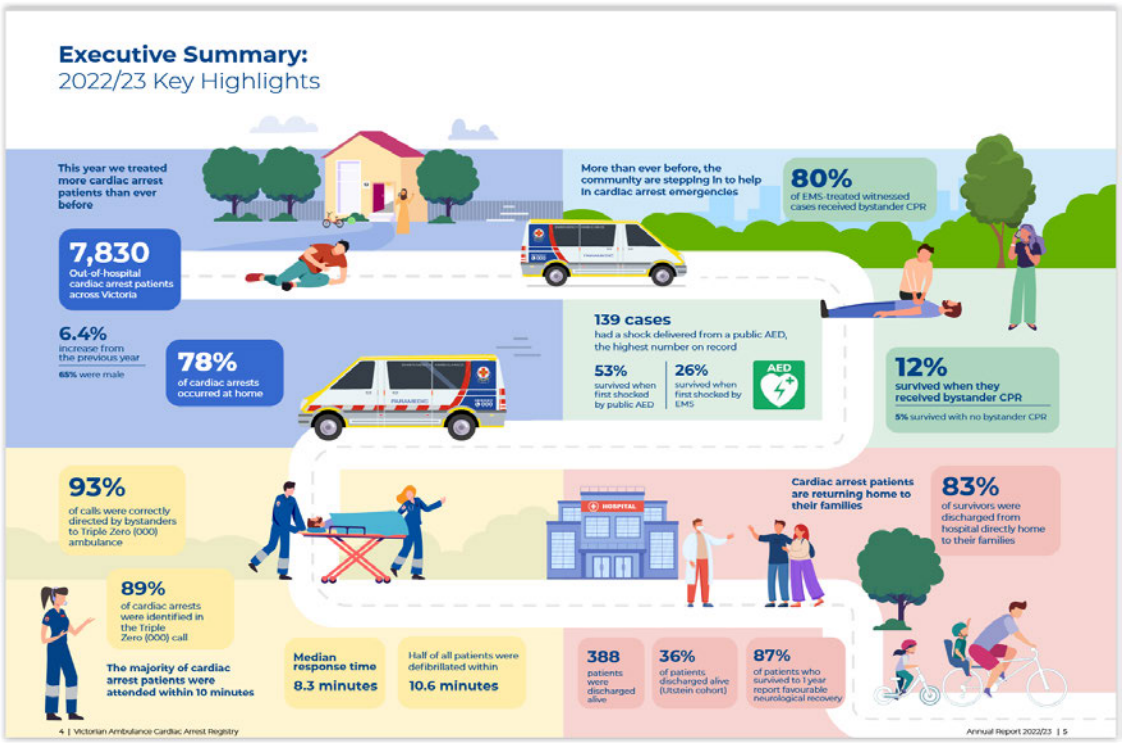

Figure 11. Executive Summary – VACAR 2022/23 Key Highlights

[18] Ambulance Victoria, *Victorian Ambulance Cardiac Arrest Registry Annual Report*, https://tinyurl.com/4k23y2dy Accessed 26/02/2025.

Reality and risk

71. While the snapshot of indicators *(paras 49-70)* shows good performance in a general sense, from a risk perspective, it is unreasonable to expect that AV will not have some level of patient dissatisfaction or complaints. Given nearly 1.5 million responses in 2023-24, the likelihood of individual complaints and errors is ever-present. Few service areas are more closely scrutinised with accessible performance data than AV and the health sector generally.

72. On rare occasions, AV or its staff may make mistakes. The key is to ensure that these mistakes will be few and minor and not systemic; and that measures are in place to identify them and take swift corrective action to prevent their reoccurrence through system redesign, education and monitoring processes.

73. The Victorian Government has been prepared to examine well-founded issues of inadequate performance as evidenced by the Inspector-General for Emergency Management's Review into Preparedness for Major Public Health Emergencies including Pandemics and its Review of Victoria's Emergency Ambulance Call Answer Performance.[19]

74. Other recent reviews that have linked poor patient outcomes to resource constraints include Coronial reports and the Emergency Services Telecommunications Authority Capability and Service Review by Graham Ashton AM APM.[20]

75. Poor corporate culture is an issue that has plagued emergency and ambulance services worldwide, and AV was recently subject to an extensive independent corporate culture reviews by the Victorian Equal Opportunity and Human Rights Commission (VEOHRC). This resulted in two significant reports[21,22] and the development of a suite of internal policies and procedures along with reorganisation and management changes.

76. The VEOHRC Progress Evaluation Audit report was released in January 2025 and marks the third and final phase of the Independent Review into Workplace Equality in Ambulance Victoria. The audit reports on the extent to which priority phase one recommendations have been implemented and also identifies areas for improvement *(Appendix C)*.[23]

77. The safety and quality oversight of AV clinical operations is linked to the role of Safer Care Victoria and the obligations of AV under the Statutory Duty of Candour if a patient suffers a serious adverse patient safety event while receiving health services.[24]

78. AV is also subject to investigation by other oversight bodies such as the Independent Broad-based Anti-corruption Commission (IBAC) which is responsible for preventing and exposing public sector corruption and the Victorian Auditor-General's Office (VAGO), which conducts audits to ensure that public sector entities are transparent and accountable.

79. Finally, Victoria has an independent Health Complaints Commissioner whose office can assist patients in resolving any complaint about a health service.

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[19] Victorian Government, *Response to the Inspector-General for Emergency Management Review into Preparedness for Major Public Health Emergencies including Pandemics and Review of Victoria's Emergency Ambulance Call Answer Performance*, August 2022. https://tinyurl.com/yktanr3p Accessed 27/02/2025.

[20] Graham Ashton AM APM, *Emergency Services Telecommunications Authority Capability and Service Review Final Report 2022,* https://tinyurl.com/4ynt6pmm Accessed 27/02/2025.

[21] Victorian Equal Opportunity and Human Rights Commission, *Workplace Equality in Ambulance Victoria, Volume 1, https://tinyurl.com/suba8n5z* Accessed 27/02/2025.

[22] Victorian Equal Opportunity and Human Rights Commission, *Workplace Equality in Ambulance Victoria, Volume 2*, https://tinyurl.com/2s3k95t4 Accessed 27/02/2025.

[23] Victorian Equal Opportunity and Human Rights Commission, *Phase 3: Progress Evaluation Audit*, January 2025. https://tinyurl.com/6cs3nhss Accessed 27/02/2025.

[24] Safer Care Victoria, *Statutory Duty of Candour and protections for SAPSE reviews*. https://tinyurl.com/2s3fz8zx Accessed 27/02/2025.

Insight 8. At a global level, Ambulance Victoria performs well but is under significant pressure with funding shortfalls that give rise to staffing and resource shortages. Long-term funding must be incremental and indexed to inflation and workload.

Insight 9. The recent decline in Victorian government funding and the relatively static and vulnerable contribution from transport fees and other income call into question the sustainability and equity of the AV funding model.

Insight 10. Ambulance Victoria and related entities have been the subject of multiple reviews across many operational areas and are subject to independent oversight and investigation by law enforcement, anti-corruption, audit and other agencies.

Paramedicine as part of the health reform process

80. Primary care remains the most immediate source of health services for many communities and can play a key role in reducing the load on hospitals, acute care and specialist services.

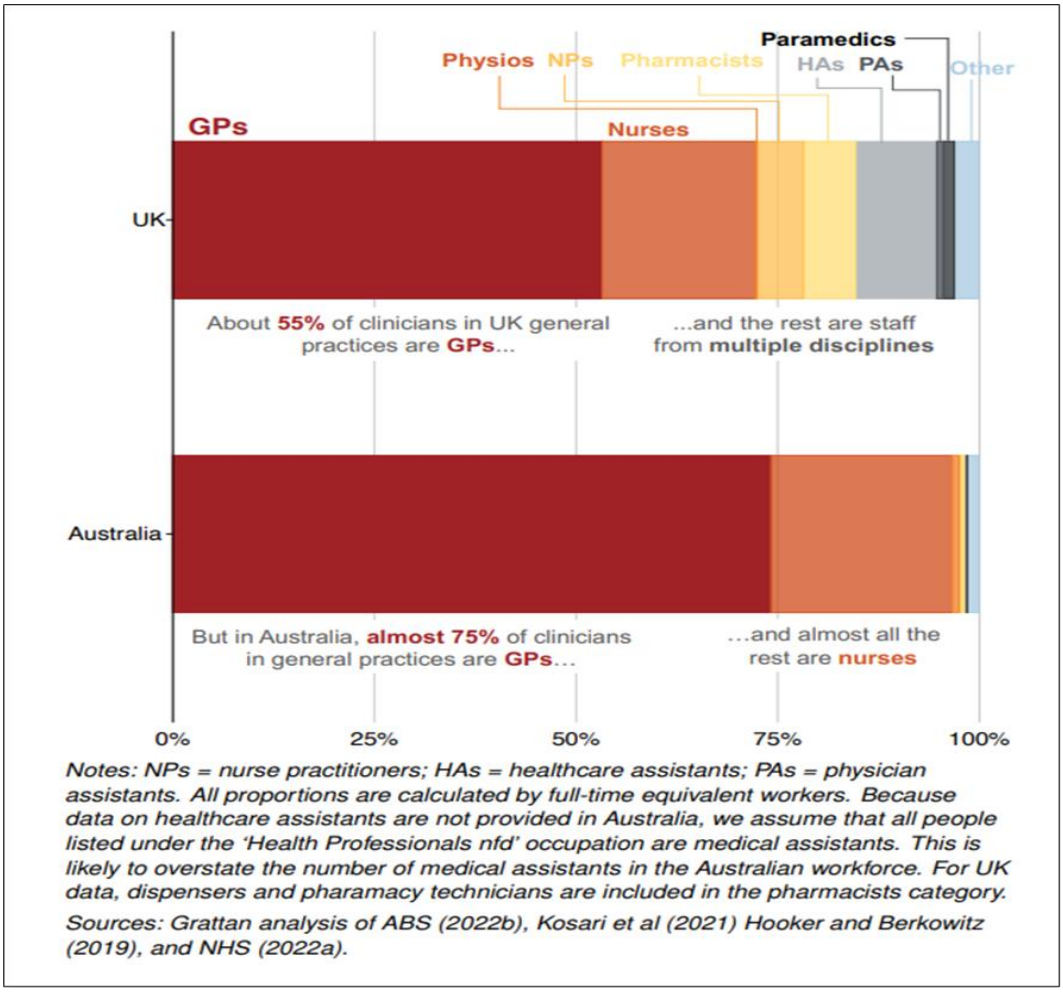

Figure 12. Distribution of the health workforce in general practice

81. Australia has been slow to take account of changes in education and training pathways or to embrace interdisciplinary practice using the expertise available from the AHP workforce *(paras 24-29, Figure 12).* That includes paramedicine, which is often the 'forgotten health profession.' This slow engagement has been attributed to several causes, including a lack of awareness of contemporary AHP capabilities.

82. Ambiguity in the definition of allied health and outdated documentation also see paramedicine variously included or omitted as an eligible profession under the current Commonwealth Workforce Incentive Programs (WIP) and other programs of support for AHPs administered by Rural Workforce Agencies.
83. The Commonwealth has paid little attention to the role that could be played by the paramedicine cohort as an independent health workforce. It is inexplicable that the 2022 Department of Health and Aged Care (DoHAC) *Allied Health workforce data gap Issues Paper* does not mention paramedicine or the role of the public ambulance services despite Paramedicine Practitioners appearing in the DoHAC summary statistics dashboard under the category of Allied Health.
84. Paramedics possess a blend of clinical expertise and situational awareness that is valuable in stressful situations. These attributes are desirable for clinical engagement and leadership roles in urgent care clinics, hospitals and multidisciplinary teams.
85. The important issue is that our communities should enjoy better health and wellbeing support through mobilising the available cohort of paramedics wherever feasible.

> *"Given the extensive training paramedics receive, the way this skilled workforce is currently used is so wasteful … "*
>
> *Professor Peter Cameron MBBS, MD, FACEM, FIFEM, FCEM(Hon)*
> *Past President, International Federation for Emergency Medicine*[25]

86. Victoria has moved to recognise paramedicine with the funding of a centre of excellence and updated legislation that reflects the contemporary legal framework of registration.[26] The Victorian Public Health and Wellbeing Amendment Bill 2022 made several key changes, including definitions under the Act. References to 'Ambulance Officers' and 'Ambulance Paramedics' were removed, and the Act now simply refers to registered paramedics.[27]
87. More recently, the Drugs, Poisons and Controlled Substances Amendment (Paramedic Practitioners) Bill 2024 was passed in the Victorian parliament. This will empower appropriately educated paramedic practitioners to obtain, possess, use, supply, administer and prescribe medicines in providing treatment for patients.[28]
88. Although Australian paramedics already are working across a wide variety of health and care settings, their engagement in community and general practice roles is less well developed than in the UK, where paramedics increasingly work in primary and other care settings, either via direct employment or on rotation from NHS ambulance services.
89. The UK College of Paramedics published a *Post Registration – Paramedic Career Framework* diagram in 2015 that has helped to provide clarity for paramedics, employers, other health professionals, and statutory and regulatory bodies on the capabilities of contemporary paramedics through a visual description of career opportunities. The framework is now in its 5th Edition and published as the *Paramedic Career Framework 2022 5th Edition Revised 2024*.[29]
90. In addition to recognising the wider role of ambulance services as part of the health and care system, the UK has seen significant mobilisation of the paramedic workforce as individual practitioners within primary care. Ambulance services compete with other public and private employers to engage paramedics just as they do for other health professionals.

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[25] Cameron, Peter, @prof_cameron, 29 April 2023 8:17 pm. [Tweet], https://bit.ly/3o0XC16 Accessed 27/02/2025.

[26] Bange R, *Victoria University Centre of Excellence in Paramedicine*, The Paramedic Observer, Facebook, 2 February 2024. https://tinyurl.com/ynk7tzf3 Accessed 25/02/2025.

[27] *Public Health and Wellbeing Amendment Bill 2022*, Parliament of Victoria. https://bit.ly/3MoDFYr Accessed 26/02/2025.

[28] Bange R, *Victorian paramedicine legislation,* The Paramedic Observer, Facebook, 3 February 2025. https://tinyurl.com/mraenb4z Accessed 25/02/2025.

[29] *Paramedic Career Framework 2023 5th Edition*, College of Paramedics, Bridgewater, April 2023. ISBN 978-1-9998607-3-8 https://tinyurl.com/4pbm4a2f Accessed 27/02/2025.

91. The Australasian College of Paramedicine is currently developing a similar Australasian framework for career roles and progression. In due course, this should help inform the nature of any future subcategories of practice and specialist career roles and classifications.[30]

Insight 11. The Commonwealth has been slow to recognise paramedicine as an independent health profession within the Allied Health cohort with the capacity to provide care across many practice settings including primary care.

Insight 12. The Victorian government has recognised the expertise of paramedics as registered health professionals through legislative amendments and dedicated funding of paramedic practitioner education and research.

Insight 13. The Paramedicine Board of Australia (PBA) has defined the qualifications and capabilities required for paramedic registration, emphasising the autonomy of practice and alignment with other OSCA[31] Level 1 Health Professions.

Insight 14. Australia should learn from the UK where paramedics continue to develop along leadership and management, education, research and development, and clinical practice pathways, with opportunities in primary, urgent, emergency, and critical care.

Paramedicine and Allied Health

92. Estimates prepared from matching PBA statistics and ROGS data (Table 11A.2) indicate that at a national level up to 30% of paramedics do not work for jurisdictional ambulance services. The percentage in Victoria may be as high as 35% - meaning that more than 2500 Victorian paramedics work outside AV and are under- or unemployed *(see Figure 8).*

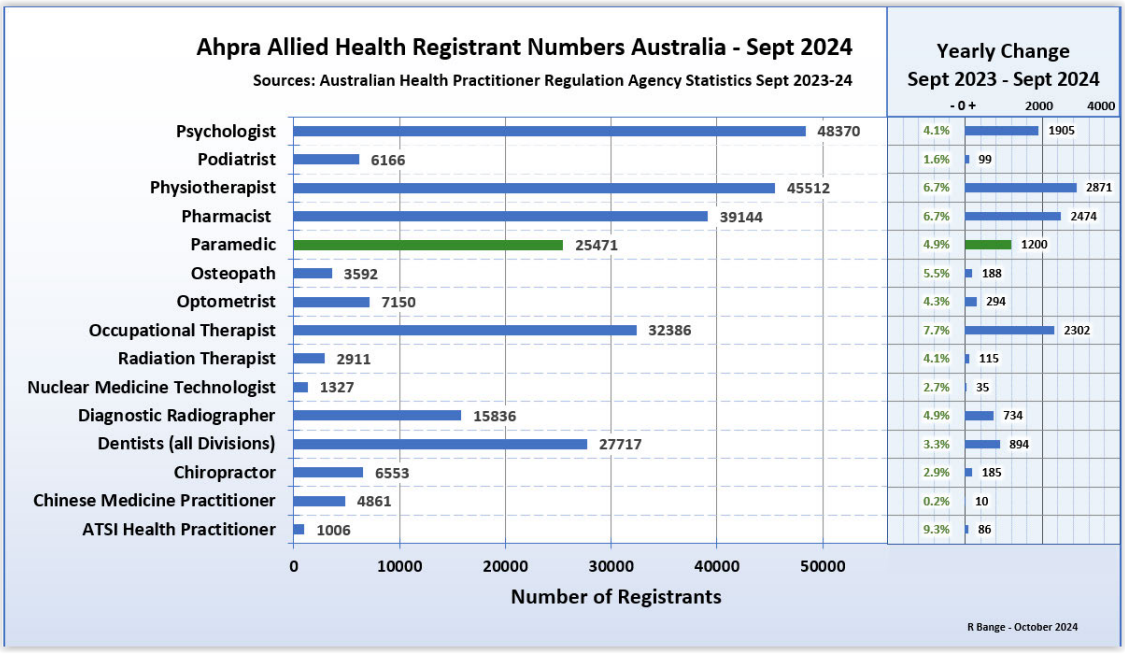

Figure 13. Ahpra Allied Health Registrant Numbers

93. Paramedicine is among the fastest growing of the regulated AHPs that have undergone rigorous assessment to ensure public safety *(Figure 13).*

[30] Australasian College of Paramedicine, *Paramedicine: Draft Clinical Practice Framework for Australasia*. https://tinyurl.com/2nkej4sw Accessed 27/02/2025.

[31] Australian Government, *Occupations Standard Classification Australia (OSCA Version1),* Australian Bureau of Statistics, 6 December 2024. https://tinyurl.com/4yu7c29m Accessed 25/02/2025.

94. Notwithstanding their contributions to healthcare, data on the AHP workforce is sparse and disconnected. While many expert bodies have called for better patient and practitioner data, it has been slow in coming.

95. With annual graduation rates exceeding 2,000 across Australia and a strong pipeline of enrolments, paramedicine is a growing and sustainable profession, providing there is long-term funding for employment in AV and elsewhere throughout health. This engagement may be as employees or as independent practitioners like other AHPs.

96. Despite widely reported shortages of healthcare workers there is anecdotal evidence that paramedics are in oversupply, with some graduates not gaining immediate employment within the health sector including the public ambulance services like AV. These graduates will add to those practitioners already available to practice across health - provided administrative and other impediments to practice are removed.

Insight 15. Paramedicine (being neither Medicine nor Nursing/Midwifery) should be included in the national and jurisdictional workforce planning datasets as an independent health professional cohort aligned with the third pillar of Allied Health.

Insight 16. Based on a national registered practitioner cohort of 26327 registered paramedics at the end of December 2024, more than 7800 paramedics are working or potentially available to work in the health system outside the ambulance service sector.

Insight 17. The role of paramedics should be considered in the context of independent registered health practitioners and not viewed as working only for ambulance services.

Workforce incentives and upskilling programs

97. A barrier to wider AHP engagement in primary care is the restriction of Commonwealth support and upskilling programs to the private sector. That requirement assumes that public sector practitioners receive equivalent continuing professional development opportunities - which has proven problematic.

98. The policy is also discriminatory and contrary to equity principles. It disadvantages patients who don't benefit from better care that would come from upskilling activities where a public sector service may be the only provider in the region. Health workers also commonly move between the public and private sectors and provision should be made for cross-sector and fractional time employment.

99. From a community service and equity perspective, eligibility for upskilling programs should be based on identification and support for local needs. Practitioners from both private and public sectors should be eligible for these activities intended to develop the capacity of the health system to support patients in the local community.

100. Victoria should support the expansion of the eligibility criteria to include those highly motivated AHPs who work in the public sector and who otherwise may be lost to the system as they move to more supportive environments and jurisdictions

101. As a corollary, health sector position statements often assign roles to specific professions, regardless of their relevance to service delivery. Instead of naming a profession (unless clinically necessary), job specifications should emphasise the required skills, experience, and responsibilities of the role, potentially increasing the pool of available candidates.

Insight 18. Paramedicine has been variously included and/or omitted as an eligible profession for AHP workforce support in documentation scattered throughout the health policy domain.

Insight 19. Commonwealth support for independent AHP practice is limited. The available incentive and upskilling programs for AHPs are commonly restricted to private sector employment which limits cross-sector (public/private) employment.

Insight 20. Position statements are often ring-fenced to nominated professions where the functional job requirements could be performed by AHPs like paramedics.

Paramedics and community integrated care

102. Preventive healthcare helps people live longer in good health and reduces the overall burden on health and social care resources. The growing unfilled demand for human and physical resources and the pressures on healthcare are becoming more concerning as evidenced by long wait times for medical treatment and elective surgery, bed block in hospitals, and ramping of ambulances in jurisdictions across Australia.

103. Community paramedicine programs are alternatives to traditional ambulance service response and aim to address overburdened hospitals and fragmented primary care. 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 *(para 29).*[32, 33]

104. There are many international case studies and evaluations of successful community paramedicine activities. These include the Renfrew County Paramedics program https://bit.ly/2GT7Szu; NHS Agreement to formally support the role of community paramedics https://bit.ly/2OLCFoB; Mobile Integrated Health system in Alberta https://bit.ly/2MGkJtU; and the evaluation of community paramedicine in Ontario https://bit.ly/2YO0pfj.

105. In Victoria, the HMS Community Homecare and Clinic offers community paramedic and multidisciplinary services that reduce 000 calls, ambulance callouts, and hospital visits, potentially reducing other pressures on AV and ambulance ramping. Their care model sees community paramedics assessing and treating people in their homes and developing long-term plans as a multidisciplinary team of nurse practitioners, paramedics, nurses and AHPs. The service is a registered charity supported by community donations, with one key missing factor - sustainable long-term state or federal funding.

106. Greater mobilisation of the paramedicine cohort holds the prospect of enhanced interagency and rotational work with hospitals and other care agencies[34, 35] including GP practices, urgent care centres, mental health, and palliative services. Providing healthcare that is close to home should help to ensure the right care, right patient, and right time.

107. These principles align with current national policies that envisage the growth of integrated out-of-hospital care to cater for an aging population and increasing incidence of chronic conditions that are seen to be largely preventable.

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[32] Leyenaar, M., McLeod, B., Penhearow, S., Strum, R., Brydges, M., Mercier, E., . . . Costa, A. (n.d.). *What do community paramedics assess? An environmental scan and content analysis of patient assessment in community paramedicine*. CJEM, 1-10. doi:10.1017/cem.2019.379

[33] Rural Health Information Hub, *Community Paramedicine*. https://bit.ly/2EBdUG6 Accessed 05/02/2025.

[34] Australian Health Care Reform Alliance, *Health Workforce Policy Position Paper*, 28 June 2016. http://bit.ly/292oxB3 Accessed 28/02/2025.

[35] Gardiner F W, Bishop L, de Graaf B, Campbell J A, Gale L, Quinlan F. (2020). *Equitable patient access to primary healthcare in Australia*. Canberra, The Royal Flying Doctor Service of Australia. https://bit.ly/3qtsNxk Accessed 28/02/2025.

The engagement of private sector paramedic services

108. Australia has been slow to realise the full benefits of mobilising private paramedic services other than for Non-Emergency Patient Transport (NEPT) and public event support (exceptions are the contracted services in Western Australia and the Northern Territory).

109. In the UK, the private sector makes a substantial contribution to out-of-hospital care through independent private services that provide surge capacity and additional mainstream support. This engagement is possible because of the recognised competencies and legal status of the registered paramedics and the system of service provider regulation and accreditation under the Care Quality Commission.[36]

110. Victoria would benefit from legislation and policies that allowed for the engagement of private resources in times of need such as natural disasters like bushfires and floods or for support in extreme emergency response periods such as mass casualty incidents.

111. To facilitate interoperability, Victorian legislation also should provide for the interchange and exchange of practitioner training and development and the operational and clinical accreditation of all paramedic service providers – including AV.

Insight 21. Australia (Victoria) has been slow to utilise the resources of accredited private paramedic service providers. Restrictive regulatory provisions limit the service provider and practitioner roles in providing collaborative care.

Insight 22. Victoria should support a national accreditation scheme for all paramedic services (beyond the basic NEPT level) to ensure the safety and quality of care and to facilitate interoperability, community resilience and surge capacity in times of need such as disasters and thunderstorm asthma events.

Embedding AHPs in primary care

112. GP practices in England work together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups known as Primary Care Networks (PCNs). The Additional Roles Reimbursement Scheme (ARRS) was introduced in 2019 to improve access to general practice by supporting the recruitment of additional staff across designated roles including paramedicine.

113. The ARRS provides for reimbursable practice roles to enable each PCN to add various AHPs to make up the multidisciplinary workforce they need. PCNs can decide the distribution of roles required and can engage community-based partners if they don't directly engage a practitioner.

114. A paramedic in primary care can provide a rapid response to deteriorating patients and patients with long-term conditions, minor injuries, and minor illness. They can also support patients who require wound care, have fallen, have musculoskeletal problems, and have urinary tract or respiratory infections. Paramedics can supply a range of medicines through patient group directions, including antibiotics and analgesics.

115. Paramedic support may include responding to immediate daily demand by offering telephone triage or undertaking home visits while they can help to improve access to care by managing minor ailments and seeing patients in care homes.

[36] Care Quality Commission, *About us, The independent regulator of health and social care in England*, https://www.cqc.org.uk/about-us accessed 12/02/2025.

116. An underlying feature of the ARRS is the recognition of AHPs as a valuable part of the primary care team - while the inclusion of community paramedics acknowledges the value of paramedicine in primary care and multidisciplinary teams:

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

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

118. To foster practice development, Health Education England commissioned a *Paramedic (Specialist in Primary and Urgent Care)* core capabilities framework to support those paramedics working in primary and urgent care. It also provides advice to practitioner groups on the role of paramedics and their integration into general practice.

119. While the PCNs swiftly engaged these roles, the evidence shows the ARRS practitioners could be integrated better into primary care teams. These findings came from a King's Fund project to explore the factors affecting the implementation of ARRS roles within general practice, and what might be done at national and local level to address the challenges.[37]

120. The King's Fund research focussed on four roles: social prescribing link workers; first-contact physiotherapists; paramedics and pharmacists. These were selected because they had been covered under the ARRS for the longest period; they represented a mix of both clinical and non-clinical roles; and they involved a mixture of employment models.

121. The study found a lack of shared understanding about the purpose or potential contribution of the ARRS roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs and their working practices, both clinically and operationally.

122. Successful implementation of the ARRS scheme was found to require extensive cultural, organisational and leadership skills that are not readily available, nor present in many practices. Implementation was also complicated by the impacts of the Covid-19 pandemic. A variety of support mechanisms as well as stability and continuity of funding were seen as critical to the effective integration of ARRS roles within general practice.

123. This research suggests that the scheme should have:

- a clearer, shared vision for a multidisciplinary model of care;
- a comprehensive package of support for implementation including improved support for clinical and managerial supervision;
- streamlining and communicating current guidance and roadmaps to make them more accessible and practical to understand and implement;
- a focus on future sustainability, including funding and career progression; and,
- leadership and management skills embedded in GP specialist training.

[37] Beccy Baird, Laura Lamming, Ree'Thee Bhatt, Jake Beech, Veronica Dale, *Integrating additional roles into primary care Networks,* The King's Fund, London, February 2022. https://tinyurl.com/2t9jpyx2 accessed 15/10/2023

124. These findings reinforce the importance of a collaborative approach in developing practice literacy, funding and support arrangements, and formal articulation of suitable frameworks to facilitate wider engagement of paramedics and other AHPs in primary care.

125. The author agrees. It's not enough to look at the number of health professionals in a jurisdiction. The team composition and skill-mix requirements need to be addressed at a more localised level. There's a glaring gap in service understanding.

126. Health workforce planning is typically not integrated with planning for health care services and health care funding, despite these roles being strongly interrelated. That's especially the case when one sees a virtual absence of any consideration of ambulance services in national policies and funding *(paras 82-83).* Are the nearly one million patients looked after by AV in 2023-24 to be ignored *(para 45-49, Figure 4)*?

127. A significant issue is how enhanced personal skills and capabilities will be applied in practice. That is why support for the employment infrastructure (like AV and GP practices) is important if the full benefits are to be realised from expanded scopes of practice.

128. When it comes to Commonwealth support programs like the Health Workforce Scholarship Program, the needs are local, and grants should be based on those identified requirements on an individual basis and not on some public/private divide *(paras 97-101).*

129. There needs to be a collaborative framework or mechanism to facilitate place-based workforce planning and implementation including the best ways to incorporate clinical roles, non-clinical roles and digital innovations that meet the healthcare needs of communities. The Health Department and AV need to consider paramedicine in the context of a national workforce and the role of the Commonwealth *(Recommendation1).*

130. National consistency is desirable, but Victoria might take unilateral action to remove obsolete jurisdictional barriers to practice. Longer term however, establishing an efficient and effective multidisciplinary workforce will need collaboration across national and jurisdictional governments, given the traditional allocation of separate responsibilities in healthcare administration, funding, and regulatory arrangements.

Insight 23. Effective infrastructure support, such as clinical governance, changes to operational practices, funding and other resources, is needed to support each team member to work to the top of their scope of practice.

Insight 24. To facilitate the wider mobilisation of AHPs (including paramedics) in primary care, Victoria might collaborate with other Australian jurisdictions and professional bodies in developing materials to support the engagement of these practitioners across a variety of public and private practice settings.

Insight 25. Many restrictions on advanced practice and wider employment of paramedics (and other AHPs) in primary care are administrative and the result of inadequate review processes such as might have occurred following national registration of the profession *(Appendix D).*

Observations on the ToR and Appendix B

131. The Inquiry ToR cover an enormous scope with each topic holding the potential for an independent investigation and report. In some cases, these studies have already been done recently, such as the extensive examination of workforce culture by the VEOHRC.

132. Media articles and union claims supported by published performance data and independent surveys *(paras 60-61)* reveal a healthcare system under significant stress, with AV bearing the brunt of systemic inefficiencies. Paramedics in 2023-24 reported high levels of overtime, ambulance ramping at hospitals, a dispatch system they say wrongly classifies minor incidents as code-one “lights and sirens” emergencies, and internal management turmoil.

133. Given a resource-constrained environment, the challenge has been to do more with the same or fewer resources *(para 45, Figure 3, para 54, Figure 5).* In a pressure-cooker environment, even minor delays can become emotionally overwhelming, while unrelenting stress can lead to burnout and PTSD. Sensitive management monitoring and support are crucial in maintaining practitioner health and wellbeing.[38,39]

134. Appendix B outlines issues raised with the author by paramedics, other health professionals, patients, family members and policy researchers. These inputs come from different levels of expertise and range from patient reactions to well-founded and knowledgeable professional observations.

135. Some criticisms of AV (and individual staff members) appear to arise from legitimate failings and would warrant further verification and in-depth investigation to determine future action. Selected matters have been consolidated and are covered in the following paragraphs.

Ambulance Ramping and Response Times

136. Ambulance ramping and delayed response continue to be present in Victoria and operational data is now published regularly. The complex reasons behind ED overload and bed block have been extensively explored across Australian and overseas jurisdictions and measures to minimise its occurrence are being trialled and/or implemented.[40,41]

137. Potential solutions include better integration between ambulance services, hospitals, and community care providers; more funding to overcome workforce shortages and physical infrastructure gaps, new handover protocols to limit the time for transfer, [42] diversionary mechanisms including alternative care options such as virtual emergency triage and telehealth and even public awareness campaigns about appropriate ambulance use.

138. A renewed focus is being placed on primary care, aged care, mental health care and palliative care. These and other measures target broader issues, such as models of care aimed at easing pressure on hospitals and supporting care in the community, including initiatives relating to virtual care, increased subacute care, and primary health.

139. These approaches to preventive care and diversion to more appropriate care than EDs are intended to expand the capacity of the health system and the available resource base in coping with an increasing healthcare workload.

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[38] Bange R, *Deadly delay:observations on ambulance ramping and the delivery of sustainable health services in New South Wales,* Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales, Parliament of New South Wales, September 2022. https://tinyurl.com/4afmc4xm Accessed 22/02/2025.

[39] Bange R, *Mental health and paramedics: Submission for the Senate Inquiry into the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers*, Senate Education and Employment References Committee, Parliament of Australia, Canberra, June 2018. https://tinyurl.com/2u6vpj6z Accessed 23/02/2025.

[40] Bange R*, Patient transfer delay harm,* The Paramedic Observer, Facebook, 26 August 2023, https://tinyurl.com/bdzemwyy Accessed 22/02/2025.

[41] House of Assembly Select Committee, *Transfer of Care Delays (Ambulance Ramping),* Parliament of Tasmania, 11 November 2024. https://tinyurl.com/yu659m5n Accessed 24/02/2025.

[42] *Standards for Safe and Timely Ambulance and Emergency Care for Victorians*, Department of Health, Melbourne, Victoria, February 2025. https://tinyurl.com/5n8y7apy Accessed 28/02/2025.

Expanding the resource base

140. Concern has been raised at the inability of the medical and nursing workforces to meet future workforce demands. Only recently has attention turned to the underutilised expertise of AHPs like registered paramedics who can work autonomously and assume clinical and leadership roles in multidisciplinary healthcare settings.

141. The engagement of paramedics more generally throughout health has also been limited by outdated barriers from a time when paramedics were primarily employed by ambulance services. Many of these impediments are unwarranted but remain embedded across regulations and administrative guidelines and policies at both state and federal levels and were identified in the Scope of Practice Review *(paras 28-29).*

142. Extending the role and scope of practice of paramedics would provide them with increased multidisciplinary skills *(paras 47-48, 86-87)*. This would allow them to care for people in both homes and healthcare facilities, reducing avoidable hospital admissions and use of AV. Increasing the number of extended care paramedics in the community should also decrease transport to the ED by providing direct care in community settings *(paras 104-105).*

143. To support such initiatives, a review of funding models is required, including the fee-for-service approach, to account for the true cost of servicing diverse patient groups. Regulatory frameworks for service delivery and payments need review. Unlike other health practitioners, paramedics currently lack the authority to directly approve payment for Medicare-funded services which is a Commonwealth matter *(paras 105-107).*

144. Alongside the recognition of paramedicine as a discrete professional workforce for planning purposes, registered paramedics should be recognised for direct reimbursement for their medical services. This matter needs to be pursued at the Commonwealth level.

145. Innovative solutions are required to improve access to allied health care and integration of this workforce group with primary care networks, hospital and health services, aged care services, disability services, schools and other community services.

146. Funding is needed for health education to increase health literacy and for health promotion and workforce policies to support public, not-for-profit and private service capacity.

147. Greater investment in telehealth services, extended care paramedics, specialised community support teams, and secondary triage are all measures that would help to provide better care and alleviate transfer of care delays.

Toxic Workplace Culture

148. Governance underpins corporate culture and plays a key role in interpersonal outcomes, which are then reflected in the operational performance of an organisation. Research studies have shown that there is a direct correlation between positive morale and overall well-being and productivity (in this case – patient care).

149. Job satisfaction, employee health and well-being and overall attitudes within the workplace hold great significance in terms of strengthening resilience.

150. It is in the public interest that AV be imbued with good morale and that its personnel share a common goal of transparent best practice healthcare delivery. That view of transparency aligns with the Duty of Candour principle *(para 77).*

151. While most often applied to patient relationships, the principle also means that healthcare professionals must be open and honest with their colleagues, employers and related organisations and take part in reviews and investigations as needed.

152. The principle requires healthcare professionals to raise concerns where appropriate. They must support and encourage each other and not prevent anyone from raising concerns. These practices are conducive to good morale and participative management in any setting.

153. Paramedics have described the presence of cultural deficiencies leading to a lack of personal confidence and trust. These behavioural patterns are not uniform, with the experiences described across different regions showing significant variability.

154. That suggests individual management failings that have not been balanced by organisational mechanisms that ensure procedural consistency, respect, and empathy both with the circumstance and the mental state of the individual practitioner or staff member. (This submission does not address individual concerns or complaints.)

155. Staff retention alone is not a reliable indicator of job satisfaction and mental wellbeing *(paras 60-61, Figure 7).* Employees may remain with an organisation despite a poor working environment for various reasons. These include the intrinsic altruism of paramedics and volunteers, geographic ties with housing, school and other family commitments, financial and career reasons or limited alternative employment opportunities.

156. Good employee morale must always be a key objective of AV whose workforce is exposed to stressors that have been shown to result in a higher than average incidence of Acute Stress Disorder or Post Traumatic Stress Disorder (PTSD) and sometimes even suicide.

157. A culture of bullying, harassment, and misogyny in the past within AV undermined staff morale and led to an extensive cultural climate review by the VEOHRC. Phase three of that review process has seen a further progress report showing that some work remains to be done *(paras 76-77, Appendix C)*.

158. Despite the progress report identifying areas that need to be completed, staff attrition has remained relatively modest *(paras 60-61)*. Organisational change management poses many challenges and requires strong leadership and commitment, resources and time. The COVID-19 pandemic and tight expenditure constraints in recent years are likely to have impacted progress *(paras 53-54, Figure 5).*

159. Given these corporate culture matters are being actively addressed by the VEOHRC no advice is offered except to endorse that on-going process and emphasise that funding needs to be appropriate to drive change through training and staff renewal.

160. In addition, mental health injuries should become part of the annual occupational health and safety reporting for AV and in time, be incorporated in ROGS along with national performance metrics by all ambulance services.

Fraud and Corruption allegations

161. As a senior consultant with integrity agencies for more than 15 years, the author has undertaken several forensic reviews of hospital and ambulance organisations and is acutely aware of the corruption and fraud opportunities that may be present. The risks are manifold and heightened by the nature of the autonomous working environment, specialist activities and terminology, expensive equipment and association with restricted drugs of dependence.

162. AV is subject to the normal oversight provisions for Victorian government agencies *(paras 79-80).* It has an internal audit committee and comes under the purview of VAGO, IBAC and the Police, which have established reporting, protected disclosure and investigation procedures.

163. These oversight mechanisms have been activated in the past, such as the 2015-2017 IBAC investigation into allegations that AV paramedics engaged in serious corrupt conduct involving the theft, trafficking and use of drugs of dependence and misappropriation of AV equipment (Operation Tone).[43]

[43] IBAC, *Operation Tone,* Independent Broad-based Anti-corruption Commission, Melbourne, Victoria.18 September 2017.

164. For practitioner-related and clinical issues, there is Safer Care Victoria and an Independent Health Complaints Commissioner as well as the fitness to practice provisions and notifications under the Health Practitioner Regulation National Law *(paras 78, 80).*

165. The author is unaware of any new or unreported specific allegation of potential fraud and corruption that would warrant referral to any of these oversight and regulatory bodies or which identify procedural flaws in AV accounting and procurement governance. Should credible allegations be lodged, the established procedures for investigation should be undertaken with reporting to the relevant oversight body.

166. Based on experience, there are likely inherent dangers of conflict of interest, and potential variations in investigation standards and outcomes. The author suggests that a fraud and corruption risk review across AV would always be desirable, and discussions might be held with IBAC to undertake such a review.[44]

Triage and Dispatch Systems

167. Deficiencies in triage and dispatch systems were the focus of recent in-depth reviews leading to Government in-principle support for the seven recommendations from the Major Public Health Emergencies Review and the eight recommendations from the Ambulance Call Answer Review. Another study was the Emergency Services Telecommunications Authority Capability and Service Review by Graham Ashton *(paras 73-74).*

168. That review also noted the challenges of restructuring and cultural change (p 3):

> "To truly establish the foundational elements underpinning the future state of ESTA, implementation of recommendations from the Review will be complex and should not be rushed, but equally must be progressed as a priority. ESTA and its leadership must continue to implement immediate enhancements to address critical service delivery issues impacting the community at the present time, however, the desired future state is not a 'quick fix' and will require dedicated planning and sustained effort over time."

169. The author makes no additional recommendations while awaiting a progress evaluation report. Meanwhile, the VVED has been implemented *(para 48)* and AV has been actively recruiting staff for its growing secondary triage team.

Access and Equity

170. Geographical and other practical constraints will always place limitations on the capacity of AV (and the healthcare system) to respond to emergencies and other calls for assistance. It is the task of the government to allocate resources to fulfil the social contract it holds to ensure that communities receive fair and equitable services to the extent feasible.

171. Many observations about AV *(Appendix B)* have a common thread that confirms other indicators pointing to continuing resource limitations *(paras. 53-54, Figure 5).* Comments also show that public expectations about the level and timeliness of services are high and subject to intense media attention because of the impact of healthcare on the community.

172. When it comes to continuing education and upskilling activities to support the workforce required to staff healthcare facilities, current Commonwealth policies that exclude public sector employees from eligibility unrelated to local needs are perceived as discriminatory and likely to make regional appointments more difficult *(paras 97-100).*

173. The author acknowledges the innovative steps already taken by the Victorian government to build a stronger health workforce containing paramedics through legislative reform, support for a centre of excellence and collaborative development of additional educational opportunities for AV personnel, but the Commonwealth needs to do better.

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https://tinyurl.com/bddf5enh Accessed 28/02/2025.

[44] IBAC, *Controlling fraud and corruption: a prevention checklist*, independent broad-based anti-corruption commission, Melbourne, Victoria. https://tinyurl.com/4snx56p6 Accessed 28/02/2025.

Recommendations

172. This submission has highlighted the expertise and availability of registered paramedics to work autonomously as AHPs and assume clinical and leadership roles in multidisciplinary healthcare settings including AV. Several insights are offered to show where policy decisions may be taken.

173. Examination of AV revenue and expenditure and transfer of care delays indicate an under-resourced health system that has not kept pace with community healthcare needs. There has been insufficient funding to ensure the infrastructure and level of nursing, paramedic, allied health and ancillary staff required to operate the Victorian health system to national benchmarks. Improved performance by AV and reduced ambulance ramping will require innovation and additional investment in not only AV but also other areas.

174. The immediate issue is how to undertake major changes in the complex healthcare system whose funding and regulatory systems span local, jurisdictional, and national policies and structures. Because of these interrelated issues, the recommendations need to be considered as a package.

Recommendation 1 - Recognition and funding of the ambulance service

a) Victoria should more positively identify AV as the essential provider of both public emergency and community healthcare services within the health and care system.

b) To ensure more equitable access, basic ambulance service funding should be delivered through a single stream of government funding and be nominally free for residents.

c) Based on historical data, government funding of AV should be significantly increased by at least $300 million in $2023-24 values for the current year to support the engagement of additional personnel and continued investment in infrastructure resources and physical assets to match the growth in service demand. A more nuanced cost-benefit analysis including potential savings has not been feasible in the time available.

d) Recognising the growing community health role of AV, Victoria should negotiate an amendment of the National Health Reform Agreement with the Commonwealth to provide funding for AV either fully or on a dollar-for-dollar basis, matching the contribution of the state.

Recommendation 2 - Recognition of the paramedicine workforce

a) To strengthen the health workforce, Victoria should formally recognise paramedicine in workforce statistics, policy development, planning, and service purposes and advocate for this recognition by the Commonwealth.

b) This recognition would involve identifying paramedics in policy and media documents and potentially aligning them with Allied Health or as a separate professional cohort.

c) The paramedicine profession should then be engaged consistently as one of the key stakeholders in policy deliberations on healthcare and overarching health policy and disaster response at state, territory, and national levels.

Recommendation 3 - Engagement of paramedics across the public sector

a) The Victorian Department of Health should actively explore the wider utilisation of paramedics in the public hospitals and other public health and care settings, including longer-term senior citizen and aged care, custodial care, drug injecting and community care, palliative care, and mental health care.

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

Recommendation 4 - Review of position descriptors and duties

a) Future appointments within the Department of Health should be based on position descriptions and job specifications that outline the functional responsibilities, required skills, and relevant experience for each role. The nomination of a specific profession should be minimised unless it is necessary for clinical purposes.

b) Appointment-related documentation for health personnel should be reviewed periodically, where feasible, to ensure it remains gender-neutral and free from professional bias to the extent required.

Recommendation 5 – Removal of impediments to practice

a) Victoria should explore the impediments to practice by registered paramedics at both jurisdictional and national levels. The objective should be to enable access to MBS/PBS provider programs, referral pathways, prescribing rights *(see paras 48, 86-86)*, access to electronic and other health records, and other elements of independent practice.

b) This activity should be consistent with the findings and recommendations of the national Scope of Practice Review *(paras 28-29).*

c) Other States and Territories should be encouraged to examine barriers to AHP practice at jurisdictional level, with the inclusion of paramedicine in long-term workforce strategies.

Recommendation 6 – Wider mobilisation of the paramedicine cohort

a) Victoria should adopt affirmative action to drive wider mobilisation of paramedics across the health domain including support schemes for upskilling of practitioners working in the public sector as well as the private sector.

b) Provisions should be made for registered paramedics to access electronic medical records including advance care plans and palliative care details in real time. The objective should be to develop human resources to deliver better patient care in areas of identified need regardless of the (immediate) employment sector

c) Victoria should advocate the eligibility of paramedics for federal programs of practice support, scholarships, and incentive programs intended to foster rural and remote practice on a significant basis.

d) Support programs should enable the employment of AHPs not only as adjunct appointments to GP practices but also as practitioners in other independent provider roles germane to their practice.

Recommendation 7 – Harmonisation of drugs and poisons regulations

a) Victoria should work with the Commonwealth and other jurisdictions to implement a national approach to harmonise drugs and poisons regulations. This might involve measures to develop model legislation or consistent legislation in all jurisdictions that aligns with the MBS and national regulation of the health workforce; to reduce impediments to practice; and avoid duplication or overlap of unnecessary legislative barriers to workforce flexibility.

Recommendation 8 - Promotion of practitioner engagement

a) Victoria should engage with the Commonwealth and other jurisdictions to develop an information dissemination program and framework regarding the use of paramedics and other AHPs in multidisciplinary practice settings.

b) The materials should embrace employer groups; professional associations; the Australian Institute of Health and Welfare; the Australian Bureau of Statistics; and the Productivity Commission.

c) To ensure the resulting operational models are feasible and well-supported this program should work with the Rural Doctors Workforce Agency Network (or the relevant responsible agency network) to ensure the inclusion of paramedicine as an eligible profession for workforce support programs and in Workforce Needs Assessment.

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

Recommendation 9 - Accreditation of paramedic services

a) Victoria should advocate for the mandatory independent accreditation and licensing regime for all paramedic service providers, including those currently designated as ambulance services. The accreditation standards should include mandatory performance standards to facilitate interoperability in times of disaster or other surge demands and transparency through public reporting of performance across health service indicators including physical and mental injuries.

b) Legislation should include the capacity for registered practitioners and other personnel to undertake joint exercises, exchange and interchange engagements across accredited private and public service providers and the ADF, and for the engagement of external accredited health service providers as supplementary resources as needed.

Recommendation 10 - Support for the Extended Care Paramedic role

a) The author endorses the moves to expand support for paramedicine education programs to assist the development and use of the Paramedic Practitioner cohort including their formal education and practice foundations enabling contemporary practice interventions and the administration of medications to potentially reduce avoidable conveyances to hospitals.

Recommendation 11 – Corporate Culture

a) The author endorses the work of the VEOHRC and AV in responding to the issues associated with the corporate cultural climate.

b) AV should ensure the training of all officers in psychological first aid, with regular refresher courses. The priority for these should be senior managers, human resources and wellbeing support personnel (including peer support staff).

c) The content should embrace behavioural standards and mental health awareness including the practical application of the code of conduct, the prevention of bullying and harassment and the management of professional personnel exposed to high occupational risk.

d) Among the components of the program should be the identification of indicators of mental distress and PTSD and the appropriate responses to be taken including referral processes.

Recommendation 12 - Accountability

a) The AV Chief Executive and senior executive staff should be tasked with the responsibility for the psychological health of employed staff and volunteers as reflected in their employment performance agreements.

b) As part of the annual reporting on Occupational Health and Safety AV should publicly report the incidence of psychological injuries in the same (or appropriate) manner as physical injury reports. Victoria should also advocate extending these reporting measures to the comparative ROGS reporting of all jurisdictional ambulance services.

Recommendation 13 – Psychological health and peer support

a) AV should ensure specific training and support for nominated peer support officers including regular refresher programs and individual mentoring and assessment by professional mental health practitioners.

b) While rapid turnover or rotation is likely to be counterproductive, unbroken peer appointments should be time limited unless all assessment factors indicate continuation in the role is appropriate.

c) The service should also facilitate the certification of peer support officers through programs such as the Certificate IV in Mental Health Peer Work or the Peer Support (Accreditation and Certification) Canada program - or other suitable local program.

d) Psychological support staff should be seen to be active in the field with station visits a common activity. This plan should follow a strategy of visible presence and contact with staff as a normal occurrence and not only when demanded by events. The strategy of engagement should focus on (among other goals) reducing the perceived stigma of distress and fostering self-recognition of the need for support and self-referral.

e) AV should place an emphasis on providing behavioural support for both career staff and volunteers in regional centres and country operations which are perceived to suffer additional stressors and personalisation as a result of isolation, heightened responsibility for training and day to day leadership and management of volunteer staff.

f) The AV peer support responder services should actively assist the development of peer groups for former personnel to enable long-term association and potential follow-up in the event of late development psychological distress. These groups also may be engaged for their contributions to AV in a variety of ways including mentoring, induction, peer support and volunteer activities.

Recommendation 14 - Fraud and Corruption risk review

a) Given the constantly changing circumstances and the introduction of new technology and service arrangements, there are likely inherent dangers of conflict of interest, and potential variations or gaps in security and investigation arrangements. It is recommended that AV hold discussions with IBAC to undertakes a fraud and corruption risk review across the service.

Recommendation 15 – Triage and other innovations

a) The author endorses the work of recent studies including the Ambulance Call Answer Review and the Emergency Services Telecommunications Authority Capability and Service Review. The time needed to implement change is also noted as well as the active recruitment of staff.

b) Along with the Department of Health, AV and other jurisdictional ambulance services have been exploring and introducing response strategies including telehealth and digital innovations. This work to leverage and enhance paramedic practice and integration into the healthcare system is ongoing and endorsed.

c) The use of AI in triage or mobile health apps for chronic disease management are developments on the horizon and are reasons why AV needs good support for its research programs and university interactions.

d) To ensure these developments are pursued and evaluated, follow-up monitoring and evaluation studies are recommended.

Abbreviations

The following abbreviations are used in this submission.

ACEM	Australasian College for Emergency Medicine
AHP	Allied Health Profession/Practitioner (context applies)
Ahpra	Australian Health Practitioner Regulation Agency
ARRS	Additional Roles Reimbursement Scheme (UK)
AV	Ambulance Victoria
DoHAC	Department of Health and Aged Care (Australia)
EBA	Enterprise bargaining agreement
NHS	National Health Service (UK)
OSCA	Occupations Standard Classification Australia
PBA	Paramedicine Board of Australia
PTSD	Post Traumatic Stress Disorder
ROGS	Report on Government Services (Productivity Commission)
VAGO	Victorian Auditor-General's Office
VEOHRC	Victorian Equal Opportunity and Human Rights Commission
VVED	Victorian Virtual Emergency Department
WIP	Workforce Incentive Program

Data limitations:

Data used for this submission come from several different administrative datasets, all of which have limitations that should be considered when interpreting the results.

Appendix A – Inquiry into Ambulance Victoria ToR

On 14 August 2024, the Legislative Council agreed to the following motion:

This house requires the Legal and Social Issues Committee to inquire into, consider and report, no later than 31 August 2025, on the core issues impacting the management and functions of Ambulance Victoria, including but not limited to:

(1) issues involving call taking, dispatch, ambulance ramping, working conditions and workloads of paramedics;

(2) procurement practices, including contract management and oversight, and their adequacy in ensuring transparency, fairness, and value for public funds and identification of any systemic patterns of mismanagement or lack of oversight;

(3) allegations of fraud and embezzlement and the adequacy of financial controls and oversight to prevent misconduct;

(4) governance and accountability;

(5) the workplace culture within Ambulance Victoria, with a focus on occupational health and safety impacts, including to the morale and wellbeing of paramedics and employees; and

(6) any other related matters the committee considers relevant.

Appendix B – A summary of some key issues

The author has worked closely with paramedics, ambulance staff, hospital workers, and healthcare professionals across Australia for many years. His involvement with the Australian Health Care Reform Alliance, the National Rural Health Alliance, and Services for Australian Rural and Remote Allied Health has provided valuable insights into the healthcare system from both patient and practitioner perspectives.

His networks include professional social media channels such as The Paramedic Observer on Facebook (~6400 followers), Twitter (~2500 followers) and Bluesky (~ 375 followers). He also contributes to advisory committees, including the Sunraysia Community Health Services CP@clinic project under the Innovative Models of Care Program to provide community paramedic coordinated care across community health services.[45]

A summary of issues associated with AV is provided below in no priority order.

Issue 1. Ambulance Ramping and Hospital Bottlenecks

a) Ambulance crews are forced to wait with patients at hospitals due to bed shortages, reducing ambulance availability.

b) Prolonged ramping leads to inefficiencies, paramedic burnout, and delayed care for critical patients.

Issue 2. Resource Shortages and Workforce Challenges

a) Paramedic shortages and underemployment of qualified staff exacerbate response delays.

b) Long shifts and fatigue among ambulance crews impacts their wellbeing and performance.

Issue 3. Lack of Alternative Care Pathways

a) Limited access to GP clinics, urgent care centres, and telehealth services increases reliance on ambulances and EDs.

Issue 4. Inefficient Triage and Dispatch Systems

a) Over-triaging of non-urgent cases leads to unnecessary ambulance dispatches.

b) Poor communication between dispatch, hospitals, and ambulance crews delays patient handovers.

Issue 5. Misuse of Ambulances for Non-Emergency Cases

a) Ambulances are used as a "free ride" to hospitals to bypass ED wait times. This misuse strains resources, delaying responses to genuine emergencies.

Issue 6. Toxic Workplace Culture - common failing with EMS /emergency services

a) Bullying, harassment, and a lack of accountability within Ambulance Victoria undermine staff morale and retention.

b) Health and Safety Representatives (HSRs) face systemic resistance when raising safety concerns.

Issue 7. Inadequate Funding and Infrastructure

a) Chronic underfunding of ambulance services and hospitals leads to resource shortages and inefficiencies.

b) Temporary solutions,e.g.pop-up wards, fail to address long-term systemic problems.

Issue 8. Lack of Accountability and Transparency

a) Suppression of critical reviews and failure to act on recommendations erode trust.

b) Poor handling of complaints and claimed victimisation of whistleblowers further damage organisational credibility.

[45] Department of Health and Aged Care, *Innovative Models of Care (IMOC) Program – CP@clinic,* Australian Government, 14 October 2024. https://tinyurl.com/2he73rru Accessed 25/02/2025.

Issue 9. Delayed Ambulance Response Times

a) Long wait times for ambulances, especially in rural areas, put patients at risk.

b) Resource shortages and poor geographic coverage exacerbate delays.

Issue 10. Inconsistent Emergency Department Operations

a) Variability in ED efficiency and handover processes creates delays for paramedics and patients.

Issue 11. High Turnover of Health and Safety Representatives (HSRs)

a) HSRs face burnout due to a lack of support and organisational resistance.

a) Paramedics and HSRs lack access to mental health resources, leading to burnout and high turnover.

Issue 12. Poor Road Conditions and Ambulance Comfort

a) Long ambulance transports and poor roads cause discomfort and potential patient harm.

Issue 13. Inadequate Pain Management During Delays

a) Patients experience prolonged pain and discomfort while waiting for ambulances or hospital care.

Issue 14. Inefficient Use of Qualified Paramedics

a) Qualified paramedics remain unemployed in Victoria despite workforce shortages across health, highlighting inefficiencies in recruitment and deployment.

Issue 15. Inconsistent Handling of Complaints

a) Complaints about workplace bullying and harassment are often dismissed or mishandled, leading to a lack of resolution.

b) Individuals who raise concerns about safety or misconduct face retaliation, discouraging others from speaking up.

Issue 16. Regional Healthcare Inequities

a) Rural and regional areas face longer ambulance response times due to hospital closures and inadequate infrastructure.

b) Patients in these areas often rely on self-transport, which is unsafe for critical conditions.

c) Mental Health Crisis Management - ambulance crews are frequently called to handle mental health crises, but hospitals lack adequate resources to treat these patients. This results in recurring callouts and inefficient use of emergency services.

Issue 17. Lack of Regional Healthcare Infrastructure

a) Closure of regional hospitals and clinics forces patients to travel long distances for care, increasing reliance on ambulances.

Issue 18. Fragmented Coordination Between Services

a) Poor communication between ambulance services, hospitals, and community care providers leads to inefficiencies.

Issue 19. Insufficient Public Awareness Campaigns

a) Limited efforts to educate the public about appropriate ambulance use and alternative care options contribute to misuse.

Issue 20. Public Understanding

a) Many people misuse ambulances due to a lack of awareness about alternative care options. Public education campaigns are insufficient to address this issue.

Issue 21. Decline in Public Trust

a) Repeated failures in service delivery and lack of transparency have eroded public confidence in ambulance services.

Appendix C -- Implementation of VEOHRC recommendations

Key:

NOT YET COMMENCED	IN PLANNING AND DEVELOPMENT	IMPLEMENTED TO A MODERATE EXTENT	IMPLEMENTED TO A SIGNIFICANT EXTENT	IMPLEMENTED AND EMBEDDING

Status	Recommendation	Assessment
1	Learning through reflective practice	Ambulance Victoria's senior leadership levels have commenced reflective practices and there is a need to extend this to all levels of the workforce.
3	A holistic evidence-based prevention plan	Ambulance Victoria's delay in developing a prevention plan has resulted in missed opportunities to clarify everyone's role in preventing harmful conduct, engage and educate the workforce, and ensure visibility and accountability of prevention activities.
6	Protecting safety in isolated environments	Ambulance Victoria has completed the safety audit, but a significant amount of work remains for Ambulance Victoria to meet its positive duty obligations under the *Equal Opportunity Act (2010)* Vic in relation to workplace safety.
7	Resetting and embedding organisational values	Ambulance Victoria has developed new organisational values, but further work to embed the organisational values is needed, particularly following difficulties around the launch of the organisational values at an offsite leadership meeting.
8	Encouraging a 'speak up' culture	Ambulance Victoria has not yet commenced work on encouraging a 'speak up' culture due to delay in developing a prevention plan and needing to ensure the Professional Standards and Behaviours Department (PSBD) was operational.
9	Contact officers and local champions network	Ambulance Victoria has undertaken some preliminary work to reintroduce equality contact officers and implement a champions of change model. Broader workplace issues around trust, accountability and psychological safety may be acting as barriers to delivering the intent of this recommendation.
12	Supporting robust governance and oversight of reforms	Ambulance Victoria has progressed some governance and oversight reforms, but the current implementation approach does not adequately deliver the recommendation intent of a steering committee of specified internal and external members with a mandate to monitor and oversee reforms.
13	A victim-centred and fair report and complaint system	Ambulance Victoria has established a new organisational response to complaints through the establishment of the PSBD, but workforce experiences do not yet reflect the realisation of a safe and effective report and complaint system due to barriers to the realisation of the recommendation intent.

14	Enhancing perceptions of independence and supporting capability for the new organisational response to reports and complaints of unlawful conduct	Ambulance Victoria has implemented this recommendation but the recommendation has been flagged due to concern that an ineffective response to higher than expected PSBD case numbers will undermine reform progress.
15	Supporting staff to confidently report through anonymous pathways	Ambulance Victoria has established and promoted anonymous complaint-reporting pathways. Further work is required to ensure that confidence and trust in the system continue to be built, to fully realise the intent of this recommendation.
16	Embedding a victim-centred approach to processes and procedures	Ambulance Victoria has taken steps to embed victim-centred approaches in processes and procedures, but needs to undertake further work to strengthen and rebuild workforce trust and confidence in the report and complaint system.
18	Developing resources to support accessibility of the report and complaint system	Ambulance Victoria has developed and promoted resources that raise awareness of the new PSBD complaint process. The intent of this recommendation has been met and is being embedded.
19	Supporting transparency and developing learning tools	Ambulance Victoria has started planning for this recommendation, but no case studies or benchmarks have been developed.
20	Understanding how the report and complaint system is working	Ambulance Victoria will develop benchmarks to measure the performance of the report and complaint system in 2025.
21	Learning lessons and improving service delivery at the earliest opportunity	Ambulance Victoria has established a continuous-improvement process, but the process has some gaps, and team learning and development have not occurred. The implementation approach has been flagged due to concerns about high complaint numbers and reduced training and development resourcing.
23	Supporting the effective delivery of reporting and complaint reforms	Ambulance Victoria has acquitted this recommendation through engaging experts to contribute to the development of reporting and complaint system reforms.
25	Increasing diversity on the Ambulance Victoria Board	Ambulance Victoria has undertaken some activities to increase diversity. Scope remains to further improve Board diversity and data collection including reporting on the Board's work to promote workplace equality and progressing work to explore legislative reforms.
28	Removing structural barriers to career advancement	Ambulance Victoria has improved flexibility in Mobile Intensive Care Ambulance training, removed some managerial endorsement requirements and changed career-progression processes. However, Ambulance Victoria has not removed all requirements for managerial endorsement across career advancement and the Commission has flagged this implementation approach for reconsideration.

31	Implementing and tailoring the Think Flex First Framework	Ambulance Victoria is in the planning stages of work to implement and tailor the Think Flex First Framework, enhance the role of the People and Culture division, adopt an 'all roles flex' approach, increase flexibility and seek funding to support workplace flexibility. Ambulance Victoria states implementation of this recommendation will be achieved by 2027. The Commission is concerned that funding has not been secured to fully implement workforce flexibility and has flagged the implementation approach as significant work is required to remove barriers to flexibility in order to achieve the recommendation intent.
33	Building knowledge, capability and accountability	Ambulance Victoria has not yet commenced work to build knowledge, capability and accountability for flexibility. Ambulance Victoria advises this will begin in 2025.
36	Strengthening workplace equality education and training	While digital training modules are in place at Ambulance Victoria, they were not developed and rolled out within the original timeframe and were not accompanied by incentives for completion or completion-rate targets.
37	Embedding sustained learning and development	Ambulance Victoria has undertaken significant work to improve the Leading Together program to include blended learning over a 12-month period. The program is receiving positive feedback and is valued among managers. The delay of performance development plans has meant this learning is not yet being consistently applied, which limits the program's effectiveness to change behaviour and attitudes.
40	Updating and strengthening governance documents	Ambulance Victoria has implemented this recommendation by updating and strengthening governance documents to clearly include its 'safe, fair and inclusive' commitment. This commitment will underpin other corporate priorities and help drive workplace equality reforms.
41	Board learning through reflective practice	Ambulance Victoria has implemented this recommendation through the Ambulance Victoria Board engaging in facilitated reflective workshops to consider drivers of harmful workplace conduct. The Board's continued accountability and commitment to a safe and inclusive workplace will embed this recommendation.
42	Organisational healing and cultural change through reflective practice	Ambulance Victoria's senior leaders and other staff have participated in reflective practice workshops, but steps taken towards organisational healing and cultural change are not being felt by the wider Ambulance Victoria workforce.

Appendix D - Some impediments to paramedic practice

Australian paramedics hold exceptional skills as evidenced by those working in the private sector, ambulance services, universities and other research and clinical roles. They routinely take complex patient histories, perform detailed physical examinations, and make differential diagnoses of patients 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.

Unfortunately, at a national level, there has been limited formal acknowledgement of the clinical interventions for which contemporary paramedics are qualified. Historical barriers and outdated documentation also remain from a bygone era that inhibit their engagement.

Some of these impediments are listed in the following paragraphs (written around paramedicine, but applicable to a varying degree to other AHPs).

Embedded perceptions – There are embedded perceptions that paramedics are employed only by ambulance services. Employers and health professionals surveyed by the author remain appreciably unaware of the skillsets of contemporary paramedics and the opportunities to engage them in multidisciplinary practice.

Unconscious proximity and affinity bias - Paramedicine is commonly not included within the lists of health professions nominated as AHPs or eligible for Australian Government support.

The omission of a workforce from nominated lists of practitioners across the Commonwealth and other jurisdictions creates a situation where that workforce becomes “out of sight – out of mind”. It’s a variation of unconscious proximity or affinity bias.[46]

This skewed treatment may be unconscious – but can have significant consequences in not mobilising the best available workforces in building health teams because of a lack of knowledge of the skill sets of (the overlooked) professions.

These oversights are compounded by the dearth of paramedicine lead clinicians at policy level and the lack of comprehensive historical workforce planning profiles and practice data.

Funding barriers - 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. These impediments again may be unintentional, and they span both state and national issues with cascading implications.[47, 48]

When it comes to healthcare services, government payments are based on delivery by a healthcare professional registered with Medicare, which currently precludes paramedics. If MBS arrangements changed to enable community paramedics to claim for the delivery of health care services, other recognition arrangements would be updated accordingly.

Unwarranted administrative restrictions - Jurisdictions have had long-outdated restrictions embedded in legislation and regulatory guidelines that inhibit paramedic practice. An example of a relatively simple procedure is the administration of vaccines.

Removal of existing administrative restrictions on minor training would enable paramedics to become vaccinators if they wished. As it happens, some dual-qualified practitioners (paramedicine/medicine, paramedicine/nursing) have held the requisite vaccination certification via their alternate practitioner registration.

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[46] Tammy Xu, *26 Unconscious Bias Examples and How to Avoid Them in the Workplace*, Built In Newsletter, 16 May 2022. https://bit.ly/2lyEpmK Accessed 21/02/2025

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

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

Job specifications - Discriminatory treatment in job specifications through designated profession job descriptors unrelated to the functional job roles – and which are within the paramedic or AHP skillset.

Drugs and medications - Restrictive provisions for the handling and use of scheduled medications. Provisions to carry, store, and administer a scheduled medicine are generally not currently available to paramedics working outside the jurisdictional ambulance services. Similar restrictions apply to varying degrees across other AHPs.

Note: There have been recent changes to Victorian legislation.

Other - Other restrictions on paramedic practice are unchanged from past decades – and their continued existence reflects the pervasive nature of obsolete documentation and the situation of paramedicine often being forgotten when it comes to workforce and practice considerations since the implementation of national registration in 2018.[49]

These factors span both national and jurisdictional responsibilities. Those related to the Commonwealth arise presumably because the Australian government hasn't previously employed paramedics or funded ambulance services, while the states and territories in the past were only accustomed to dealing with paramedicine through the lens of an ambulance service.

Many of these barriers should have been removed when paramedicine became a nationally registered health profession. These changes are feasible, and the author notes the Victorian government's commitment to fund the employment of paramedic practitioners.

[49] Bange R., *The forgotten health profession revisited*, The Paramedic Observer, Facebook, 14 December 2021. https://bit.ly/31Zke6Z Accessed 23/02/2025.