



Tasmania Branch

AUSTRALIAN COLLEGE OF AMBULANCE PROFESSIONALS

SUBMISSION TO “Productivity Commission – The Health Workforce”

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Author

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The Australian College of Ambulance Professionals (ACAP) is the representative association for professionals engaged in the delivery of pre-hospital emergency medical systems through a national council and state branches. ACAP was initially established in 1973 as the Institute of Ambulance Officers (Australia) and is the peak national body representing ambulance professionals. The Tasmanian Branch welcomes the opportunity to respond to this review but is disappointed to see that in the initial consultations it appears that ambulance services or their professional and employer represented bodies were not consulted. The Australian College of Ambulance Professionals and the Convention of Ambulance Authorities represent the professional and employer interest of the industry.

There are many aspects of these terms of reference that will impact upon ambulance services both in workforce planning and in the demand for services. The purpose of this submission is to address some of the broad concepts but also to provide some insight into looking at changing the traditional role of ambulance services to meet the changing health needs and resourcing issues that are confronting the whole of health at the moment and into the future. Whilst in this submission reference will be made to specific circumstances in this state (Tasmania) but in most cases the majority of these issues are industry wide.

The education of the ambulance officer and paramedic is undergoing a massive change at the moment with the move from the VET sector to a tertiary based system. There are now several universities offering courses in the prehospital field for ambulance authorities as well as prevocational courses. This issue is the subject of a current project by the Convention of Ambulance Authorities titled the "Paramedic Education Programs Accreditation Project".

In Tasmania, all student ambulance officers undertake a Diploma level entry course offered by a university provider. This process usually takes three years but can be shortened if recognition of previous studies is undertaken. There is, however, a necessity for at least 18 months to gain appropriate experience and this is advocated by the Convention of Ambulance Authorities Education Sub-Committee. Training numbers are usually related to vacancies so in hindsight the service is always trying to play catch-up in terms of trained and qualified staff.

In Tasmania there is no pre-vocational prehospital courses offered by the University of Tasmania so any individual that is interested in obtaining this qualification must either wait and be successful in a student intake, go to a university interstate or start a like-minded tertiary qualification (such as nursing) and apply in a student intake and gain some recognition of prior learning. This means that there is a limited pool of suitability trained personnel to fill vacancies. Many that go intrastate tend not to return and many that want to undertake a pre-vocational course find the prospect of leaving the state a significant disincentive due to loss of family and social networks and support as well as the financial impost.

In 2001, the University of Tasmania and the Department of Health and Human Services did look the possibility of developing a generic health sciences program in Allied Health Professions Education Project Team as part of its Education and Workforce Planning Standing Committee but it did not eventuate. The need to provide access to a pre-vocational course in prehospital is a necessity as it will ensure that there is a trained group of suitable personnel to fill vacancies. If the local university is unable or unwilling to fulfil the role then perhaps an alliance between the ambulance service and another university provider could be established. Another aspect that could be looked at is the offering of scholarships for people to undertake training at an interstate university with a commitment to “pay” back time in the state or rural area. This is currently on offer for various other medical and health professions but not the ambulance profession.

One distracter that has impacted upon the ambulance profession is the fact that the employers are the credentialing authority. This affects the portability of ambulance qualifications between states. The fact that ambulance officers and paramedics do not have a registration system such as other health professionals adds to this portability predicament. This is further complicated that in some instances ambulance officers and paramedics are not considered to be a health profession in the strict sense of the term. In the UK all paramedics and ambulance technicians are state registered and are considered to be a health profession by legislation.

The portability problem is further complicated by the differences in the scope of practice between the same qualification levels in the various states. The UK ambulances services have alleviated this to an extent by having a national set of

guidelines.¹ This lack of commonality between state ambulance services can be a disincentive to moving to another state due to their own particularities and scope of practice. There is often a perception by state ambulance services (especially in the higher levels of practice, i.e. intensive care paramedic level) that the only that state's training and scope of practice is acceptable and that anyone from another state could not possibly be at the standard required. This is another disincentive for moving interstate and makes portability of qualifications difficult.

The impact on various health care issues, programs and initiatives on ambulance services is a factor that is not routinely encompassed in health planning. The impact of the aging population, deinstitutionalisation of mental health services and some disability services, lack of access to general practitioner services (in general) and lack of access to aged care placement are some factors that have increased ambulance workload. Many decisions that affect health care delivery are made without consultation with ambulance services to ascertain the impact these decisions will have and the service's capacity to undertake the potential increased workloads. Often ambulance services are not provided additional resources or training to deal with these "expanded" roles even though they acquire these by default. This has the effect of reducing the ambulance services emergency response capacity and prolonging response times to all cases not just emergency cases. Of course, many of these problems then create additional issues for emergency departments at hospitals.

The demand for ambulance services will only increase. In Tasmania, the ambulance caseload has been increasing on an average of 5-8% each year over the past 5 years and is expected to continue. This increase in demand has also seen the response times in this state get worse and Tasmania now has had the worst response times for the past five years. Ambulance Services need to be adequately resourced and trained if they are to continue undertaking these additional responsibilities and roles. A document that looks at the modernisation ambulance services to do this from the National Health Service in the United Kingdom titled "*Taking healthcare to the patient: Transforming NHS ambulance services*" certainly

¹ Ambulance Services Association and Joint Royal Colleges and Ambulance Services Liaison Committee. 2004. *Clinical practice guidelines: For use in UK Ambulance Services*. Downloaded 31 July, 2005 from the World Wide Web. http://www.nelh-ec.warwick.ac.uk/JRCALC_Guidelines_v3_2004.pdf

outlines some of the issues and initiatives that can be undertaken to accomplish this.²

There has been much discussion on the role of the nurse practitioner and the potential that this role may have in alleviating the current crisis in primary care services. This is acknowledged as a positive and should be pursued with all eagerness. Another area where the expanded scope of practice may assist in providing much needed health services to rural and urban areas is that of the paramedic practitioner and community paramedic. The potential of the ambulance paramedic with an expanded scope of practice is an area that has received some discussion³ but without much in the way of operationalising the concept even though Rural Ambulance Victoria has instigated a small trial of the concept in some rural areas. The reason ambulance services are well suited to this emerging role is that they have some of the skills needed already, have some of the infrastructure in place and would see it as an extension of the prehospital emergency care system. This expanded scope of practice will require additional training in order for it to be effective. Ambulance training does not prepare officers for many of the primary health issues that they would confront in the paramedic practitioner role. This was certainly the experience in the UK.

In the United Kingdom (UK), there has been much discussion on this concept and there are several areas that have introduced the paramedic practitioner and community paramedic. The National Health Service in the UK has been undergoing a massive modernisation process which addresses many of the points raised in these terms of reference. A recent document looks at the development of the Emergency Care Practitioner in the United Kingdom.⁴ There are other documents that may be relevant to this discussion and the issue of emergency health care and after hour's medical services. These include a report on the progress of

² Department of Health, United Kingdom. 2005. *Taking healthcare to the patient: Transforming NHS ambulance services*. Downloaded 31 July, 2005 from the World Wide Web. <http://www.dh.gov.uk/assetRoot/04/11/42/70/04114270.pdf>

³ O'Meara, P. Would a prehospital practitioner model improve patient care in rural Australia? *Emergency Medicine Journal*; 2003; 20: 199-203.

⁴ Department of Health, United Kingdom. 2004. *The Emergency Care Practitioner Report - Right Skill, Right Time, Right Place*. Downloaded 31 July, 2005 from the World Wide Web. <http://www.dh.gov.uk/assetRoot/04/09/30/88/04093088.pdf>

improvement in emergency care in the NHS in England⁵ and the review by the National Audit Office⁶ on emergency care in England.

The issue of the availability of general practitioners (GP) is an issue that is impacting daily on ambulance services. In some areas of the state and this is not just restricted to rural areas but many urban and outer urban areas, it is difficult to get timely appointments with GPs. Thus the ambulance service and the emergency departments become the de-facto GP service when people condition does not allow them to wait or they do not want to wait for an appointment. The inability of some GP practices to service their patients, due to increased demand as well as GP shortages, is becoming more common during the traditional GP hours. The problem only exacerbates after hours with limited access to GPs. Some GP services deputise their after hours service to out of hours clinics (not 24 hour in this state) and medical advice/triage telephone services. Again, there is an increased impact upon ambulance and emergency department services when these services are available or when actual attendance is required by the patient's presentation.

The establishment of GP services at or near acute care facilities would be a step in the right direction as it would provide a contact point for patients to attend and reduce the need for the emergency departments for presentations that could be more appropriately handled by a GP. The issue for ambulance services is that these services would not be easily accessed by certain sub-groups of the population. These include the elderly, low socio-economic groups and groups that rely on public transport. These will still require either a visit from a health professional or transport to a health facility capable of addressing their health needs.

In this state, service policy dictates that social needs are to be considered by ambulance officers and paramedics when deciding upon the need for patient transport. This often means that fully equipped and staffed emergency ambulances (some of these will be intensive care level ambulances) are reduced to becoming very expensive taxis even when the patient does not require any actual or potential ambulance interventions during transport. This may seem to be effective (getting the

⁵ Department of Health, United Kingdom. 2004. *Transforming emergency care in England*. Downloaded 31 July, 2005 from the World Wide Web.

<http://www.dh.gov.uk/assetRoot/04/09/17/81/04091781.pdf>

⁶ National Audit Office, United Kingdom. 2004. *Improving Emergency Care in England*. Downloaded 31 July, 2005 from the World Wide Web.

http://www.nao.org.uk/publications/nao_reports/03-04/03041075.pdf

patient to the health facility) but is not efficient and has the flow on effect of reducing the community's emergency ambulance capacity and prolonging response times. Also it creates a follow on problem for the patient in getting home following treatment.

Often ambulances are called out to provide an opinion about chronic medical conditions, to obtain pharmaceuticals and for the treatment of minor medical and trauma conditions. Many of these calls could have been handled by an alternative method but due to lack of systems to deal with these types of cases it defaults back to the emergency ambulance service and emergency departments. Again in the documents listed above, the UK NHS and ambulance services have implemented services such as NHS Direct (telephone based advice), telephone advice centres attached to ambulance communication centres, walk-in minor injury units, paramedic practitioners and "don't send" policies for some ambulance requests. This has had the follow on effect of reducing demand on the emergency ambulance resources and has improved ambulance response times in many areas of the UK as well as providing a better service for the public overall.

It would seem that ambulance services (in this state anyway) are not often considered in many of the health initiatives that are implemented to reduce morbidity and mortality. The UK involve their ambulance services in many of its national health initiatives such as the National Service Framework for Coronary Heart Disease which has seen the use of improved technology and drugs by paramedics to influence better outcomes for patients.⁷

In summary, ambulance services need to be considered an integral part of the health care system and not just as a transport service. Ambulance services have the ability to impact upon morbidity and mortality of patients as well present health planners with an opportunity to improve health delivery to patients and the community at large. To do this however ambulance services need adequate human and physical resources. This submission has not fully covered all of the issues or expanded upon many others but gives an overview. The Australian College of Ambulance Professionals (Tasmania Branch) is prepared to provide further comment or clarification on request of the Commissioners or their staff.

⁷ Department of Health, United Kingdom. 2004. *The National Service Framework for Coronary Heart Disease: Winning the war on heart disease: Progress report 2004*. Downloaded 31 July, 2005 from the World Wide Web. <http://www.dh.gov.uk/assetRoot/04/07/71/58/04077158.pdf>