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SUBMISSION

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AMA submission to the consultation on the proposal to regulate advanced practice paramedics

Introduction

Paramedics play a vital role in the Australian healthcare system, and the Australian Medical Association (AMA) supports them in providing immediate lifesaving care and transporting patients to hospitals.

The AMA supported the inclusion of paramedics under the National Registration and Accreditation Scheme (NRAS) in 2018.

The AMA's response to this submission is focused on the overriding need to ensure patient safety and is informed by:

- AMA 10 Minimum Standards for Prescribing
- NPS MedicineWise Prescribing Competencies Framework

The safety of the patient must be at the forefront of these models. The AMA sees risks in changes to health practitioner regulation that does not place public and patient safety at the centre. Using workforce shortages as the main reason to pursue this is unacceptable. The AMA maintains prescribing by non-medical health practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care.

The AMA notes proposals for extending independent prescribing rights to other professions are often touted as being a partial solution to address medical workforce shortages. Attempting to address workforce issues by reallocating existing professions within the NRAS and introducing new qualifications and registration will not resolve the underlying causes of the current workforce issues. Any proposed changes to professional scopes of practice should be addressed solely on their intrinsic benefits and risks — not as part of misconceived attempts to address health workforce shortages.

We remain concerned by proposals like this one, which enable health ministers to make regulatory decisions. These important decisions must not be subject to political interference. Decisions on who can practise medicine must remain with the regulator and be based on consistent standards, clinical

judgment, and public safety. The statement on page 42 highlights the AMA's concerns: "The regulation of advanced practice paramedics supports the interest from Health Ministers to establish area of practice endorsements for advanced practice paramedics and enable independent prescribing outside ambulance services."

Do you support the Board's proposal to regulate advanced practice paramedics with the proposed regulatory model and why?

The AMA supports models of care that are determined collaboratively with medical practitioners and other health professionals. The AMA can support a model where advanced practice paramedics are embedded and work in team-based multidisciplinary teams. However, we have serious reservations about the independent prescribing of scheduled medicines, as explained below.

The issue of independent prescribing of scheduled medicines

The AMA is frustrated by the suggestion that allowing health professionals to independently prescribe medicines will address Australia's workforce issues. The paper lacks a thorough explanation of how this is to be achieved, providing no models of care or collaborative structures that demonstrate how this would work.

The AMA does not support independent prescribing of all medicines, including scheduled medicines, by advanced practice paramedics. In particular, the AMA does not support the prescribing of scheduled medicines in this context due to the higher risks associated with this class of medicines.

This part of the proposal will further fragment patient care and create confusion regarding the patient's medicine regime, who is the primary prescriber and the key decision maker regarding the patient care. Adding new independent prescribers will lead to an increase in medication mismanagement, with general practitioners (GPs) having address the harms caused by incorrect prescribing. We do not believe that accruing an additional 10 professional development points per year in the specifics of scheduled medicines is sufficient to maintain a high level of knowledge in this area.

Expanding the scope of practice and enabling independent prescribing outside of ambulance services, in an attempt to 'band-aid' workforce shortages, is the wrong approach. For example, at a population health level, the AMA acknowledges ongoing concerns about the alarming spread of anti-microbial resistance. Expanding the range of practitioners authorised to prescribe medications risks diluting the public health message that prescribing must be carefully targeted and calibrated. Adding further complexity to primary care through additional independent prescribers could only make matters worse for all concerned.

Schedule 4 and Schedule 8 medicines require extensive education and training. The NPS MedicineWise Prescribing Competencies Framework provides the benchmark for safe, appropriate and quality prescribing. The framework sets high competency standards for diagnosis and prescribing, requiring prescribers to be responsible and accountable for their prescribing decisions.

The AMA would like to restate its general position in relation to models of non-medical prescribing. The AMA supports collaborative models of healthcare where non-medical health practitioners work as part of a medically led team around the patient.

Non-medical prescribing may only occur in specific situations underpinned by the following principles:

- Non-medical prescribing occurs in a medically led and delegated team environment
- Non-medical prescribing occurs in the context of 'role delegation' not 'task substitution'
- There must be formally documented, collaborative arrangements ensuring:
    - diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner
    - clear lines of accountability and responsibility
    - separation of prescribing and dispensing (with limited exceptions as appropriate in rural/remote circumstances).
- Non-medical health practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education, and training courses
- Course curriculum must meet core competencies in determining when not to prescribe and/or when to refer patients to a medical practitioner
- As occurs for medical practitioners, non-medical health practitioners should be closely supervised during their first years of prescribing practice
- No clinician should be allowed to prescribe without the ability to physically examine the patient in a timely manner. This examination should be conducted by a practitioner operating under the same clinical governance structure and using the same patient records system
- Non-medical health practitioner prescribers must bear some risk for their prescribing decisions.

Models of non-medical prescribing supported by the AMA include:

- continuation of therapy initiated by a medical practitioner as the predominant model and continue to remain with medical oversight.

Where this is not practicable or possible:

- prescribing by a protocol or limited formulary
- initiating therapy according to protocol or symptoms
- continuing, discontinuing, and maintaining therapy according to a pre-approved protocol.

Would the proposal result in any potential negative or unintended effects for people requiring healthcare, including members of the community at risk of experiencing poorer health outcomes? If yes, please explain why.

People living in rural, regional and remote Australia

People living in regional, rural and remote Australia experience difficulties in accessing healthcare compared to people living in urban areas. However, difficulties of access alone — largely related to distances rather than numbers of health professionals per se — does not justify compromising the quality of care provided to patients living in rural/remote areas. Expanded scopes of practice for non-medical health practitioners should not be offered as solutions to medical workforce shortages, particularly in these regions.

Would the proposal result in any potential negative or unintended effects for Aboriginal and/or Torres Strait Islander peoples? If yes, please explain why.

As above.

Would the proposal result in any potential negative or unintended effects for paramedics? If yes, please explain why.

Workforce

The new role also poses risks to the current precarious workforce balance, with the new advanced practice paramedics seeking to work in non-ambulance settings. This would result in a shift away from the usual and essential care roles they provide. Additionally, the role of an advanced practice paramedic will be filled by a senior paramedic. The risk with creating a new regulated sub-division of paramedicine will undoubtably shift the senior workforce away from the 'on-road' style of work into potentially more attractive roles and work-life balance arrangements.

As indicated in the consultation paper, there is a surplus of graduate paramedics. There must be adequate senior paramedics across all areas of Australia to provide the necessary mentorship. Transitioning senior paramedics away from frontline duties into such roles could create a critical void, stripping the roads of seasoned professionals whose expertise is not only vital for patient care but also indispensable in guiding and mentoring new graduates. Such a shift jeopardises both the quality of care and the professional development pipeline essential to sustaining a competent and confident paramedic workforce.

Concerningly, this proposal is creating a new stream of primary care practitioners, inevitably leading to role confusion between GPs and paramedics. There is potential for fragmentation of patient care. Additionally, if the patient's GP is not informed, contraindications could arise, posing a risk to the patient's health.

Furthermore, there must be appropriate workforce planning to place graduates and experienced paramedics in areas of need. We would like to see a national plan for the paramedic workforce that ensures mobility across jurisdictions, regardless of the ambulance service provider. This plan would

also determine where and how surplus paramedics can safely and effectively contribute to the health system, allowing data and needs to shape policy decisions.

Other costs

In addition to direct and indirect costs associated with increased prescribing, other costs associated with the Board's proposal include:

- the supervision of advanced practice paramedics by a medical practitioner or nurse practitioner
- the additional professional indemnity insurance required to cover prescribing paramedics, their 'partner authorised prescribers' and their employers
- the development and ongoing monitoring of employers' prescribing governance frameworks to cover advanced practice paramedics prescribing as proposed in the Board's consultation paper.

Are there any other potential regulatory impacts the Board should consider? If yes, please provide details.

The AMA is concerned by the following statement on page 12 of the consultation paper: "… evidence of qualifications and the right checks and balances to be in place to assure them advanced practice paramedics were qualified and safe to practice, which is achieved through regulation."

Safe practice is not achieved solely through the regulation of that profession. Regulation is a safeguard. However, it is not the only mechanism to mitigate risk. These practitioners need sufficient training, must demonstrate clinical competence, and possess the necessary skills to perform the proposed tasks.

Do you have any other feedback on the proposal?

Primary care

The AMA's 10-Year Framework for Primary Care Reform outlines how patient care is best supported through integrated, multidisciplinary healthcare teams co-ordinated through general practice. Within a GP-led healthcare team, the skills of advanced practice paramedics would be best suited to support community health needs.

However, fragmentation of care is increasing as pressure on the health system grows. The proposal to extend independent prescribing rights risks further fragmenting patient care due to poor co-ordination. This issue largely stems from inadequate links between health professionals and poorly defined clinical governance parameters. As a result, the health system faces the risk of poorer patient health outcomes, higher healthcare costs, and confusion among patients who may be unsure of whom to trust or what level of clinical expertise they are receiving.

Task substitution of non-medical health professionals for GP-led patient care — as highlighted by the United Kingdom's tragic experience of physician assistants — is increasingly proposed as a solution to

workforce pressures. However, the risks associated with fragmented patient care are too high when the solution is already available: bringing together the diverse skill set of all health professionals under the co-ordination and oversight of a GP, who has more than 10 years of specialist training for this role.

The AMA supports nurses, pharmacists and allied health professionals working as part of a multidisciplinary primary care team, but not when it excludes general practice. Attempting to address workforce issues by expanding the scope of existing professions and establishing new qualifications with minimal training presents unacceptable risks to patient safety. The UTI prescribing trial in Queensland saw at least 240 patients develop complications due to misdiagnosis after being treated by a pharmacist. The same trial saw 96 per cent of women prescribed antibiotics (suggesting overprescription) with one per cent of pharmacies accounting for 10 per cent of all antibiotic prescriptions. The World Health Organisation identifies antimicrobial resistance as a major health issue, directly responsible for 1.27 million deaths globally in 2019.

Every interaction between a patient and a GP is an opportunity for ongoing holistic care, in which advanced paramedic care can serve as an integrated — rather than independent — role. To ensure clinical safety, legal accountability, and system alignment, such a role must be structured under a delegated model. In New Zealand, advanced practice paramedics successfully work in primary care settings under the supervision of a GP, rather than practicing independently, making a significant contribution to patient care and improved health outcomes.

Overseas models

The AMA is open to discussing this proposal as being part of a collaborative arrangement. We suggest proposals need to be carefully considered and modelled to prevent the issues similar roles have caused overseas.

In New Zealand, extended care paramedics are a vital part of the primary care team, particularly in rural and high-needs communities. Their expertise in acute care, triage, and home-based assessment allow for timely interventions, often preventing unnecessary emergency department visits. Working under the supervision of GPs, and within clear clinical governance structures, paramedics contribute meaningfully to patient care **without the need** to independently prescribe. This model supports continuity of care by managing same-day presentations, supporting hospital avoidance, and enhancing patient trust through consistent, community-based engagement. For paramedics, the shift from episodic emergency response to longitudinal patient care offers a more sustainable career path and greater professional fulfilment.

The consultation paper describes the research conducted into the frameworks across other countries, and states that the United Kingdom is the only country to have implemented independent prescribing in advanced practice paramedic roles. However, no further evidence has been provided on its effectiveness, nor has a proper review of the UK model been conducted. If such a change is to be considered, the AMA must see further evidence in building a business case. The AMA questions why the health ministers are trying to model Australia's healthcare system on the failing UK model. The

UK's experience with physician assistants is a cautionary tale. Australia must not repeat the mistake of implementing unproven workforce models without rigorous, transparent evaluation. Health ministers must prioritise evidence over expedience.

Paramedic prescribers in the UK raised concerns about their views on independent prescribing in primary care in a journal article written in the Journal of Paramedic Practice:

- **Lack of clinical governance and oversight**: absence of structured clinical governance, especially in primary care settings where they may operate more autonomously than in traditional ambulance services.
- **Increased responsibility without adequate support**: burden of increased responsibility without the necessary infrastructure or mentorship to support safe prescribing practices.
- **Risk of fragmented care**: independent prescribing by paramedics was seen as potentially disruptive to continuity of care, particularly when GPs are unaware of prescribing decisions, leading to duplication or contraindicated treatments.
- **Training and competency gaps**: training programs were insufficiently tailored to the complexities of prescribing in primary care, especially for chronic disease management and polypharmacy.
- **Concerns about role creep**: role dilution, where paramedics are expected to take on responsibilities traditionally held by GPs without equivalent clinical experience.

Australian paramedics will no doubt experience the same sentiments as their UK counterparts. The AMA questions whether this proposal has been discussed with the profession itself, including its current and future paramedic workforce.

Notifications data

To support the case for change, it is essential to examine notifications data and evidence to determine whether paramedics practising at the full extent of their scope, including in extended practice roles, have been associated with any notable increase in adverse events or notifications. Although the paper indicates the Board is unaware of specific data or notifications, this does not imply that no complaints have been raised. The AMA would like to see this data be made public.

Greater consultation

To truly address the issue of advanced practice paramedics, there must be broader research, meaningful consultation, and a thorough exploration of alternative options. The paper claims, "the board has considered a number of options in developing this proposal," yet this assertion falls flat, as only two options are presented. These options lack depth and fail to reflect genuine consideration. In contrast, the AMA has several proposals and remains open to further constructive dialogue. We reject the notion of a consultation process that appears to offer choice when the outcome appears predetermined.

Absence of funding models

The AMA expresses serious concern regarding the accelerated pace of the current consultation process and the potential for a premature rollout of advanced practice paramedicine. As highlighted on page 16 of the consultation paper, there is a critical absence of developed or available funding models to support this new stream of care. Implementing such a significant change without a robust financial framework, risks undermining the sustainability and effectiveness of the proposal.

The AMA strongly suggests funding mechanisms be proactively designed and rigorously modelled prior to any implementation. Failure to do so will likely result in reactive, fragmented policy responses and hastily constructed funding schemes that may compromise care quality, workforce stability, and long-term system integration.

Proposed registration standard

Do you support the proposed requirements for initial and ongoing registration and why?

The AMA supports the principle that advanced practice paramedics must be highly experienced clinicians, underpinned by a minimum of a Master's-level qualification, to ensure safe and effective clinical practice. However, the AMA holds significant concerns regarding any policy or framework that equates the clinical scope and responsibilities of advanced practice paramedics with those of GPs.

GPs undergo a rigorous and extensive training pathway, typically encompassing 10–14 years of education, clinical training, and supervised practice. This comprehensive preparation equips GPs with the expertise to holistically assess, diagnose, investigate, treat, refer, and co-ordinate multidisciplinary care for patients across the full spectrum of health conditions and life stages.

Proposals suggesting that advanced practice paramedics — after 5,000 hours of clinical experience, a Master's qualification, and 10 additional CPD points annually — could assume equivalent responsibilities risk undermining the depth and breadth of medical training required of GPs. Such comparisons devalue the medical profession's comprehensive, longitudinal care and may compromise patient safety and the integrity of the healthcare system.

The AMA urges policymakers to ensure role delineation between advanced practice paramedics and GPs is clearly defined, evidence-based, and respectful of the distinct and complementary contributions each profession makes to the healthcare system.

Supervised practice is important, and the AMA acknowledges the Board's attempt (on page 19) to ensure new advanced practice paramedicine clinicians are supervised by a medical practitioner or nurse practitioner. If this is the proposal, the AMA strongly recommends the Board engages with the AMA and relevant medical colleges to discuss this proposal and the opportunities for the paramedicine workforce so we can move forward with a model that meets the needs of the community and has the support of the medical workforce.

Accreditation and regulation concerns

As paramedicine evolves toward advanced practice roles, there is growing concern the Paramedicine Board may lack the regulatory capacity and infrastructure to effectively oversee these expanded scopes. Without robust regulatory mechanisms, there is a risk of inconsistent standards, inadequate oversight, and compromised patient safety. To ensure safe and competent practice, it is essential to draw on the established frameworks and lessons learned from the Medical Board, which has long managed these complexities. Leveraging the Medical Board's experience can guide the development of a fit-for-purpose regulatory model that supports advanced paramedic practice while maintaining public trust and professional accountability.

Is the content, language and structure of the proposed registration standard clear, relevant and workable? If no, please describe why.

No comment.

Is there any content that needs to be changed, added or removed in the proposed registration standard? If yes, please provide details.

See above.

Do you have any other feedback about the proposed registration standard?

Any ambiguity regarding the role of the advanced practice paramedic in the workforce may lead to inconsistent practice and potential patient safety concerns. The consultation paper outlines broadly where the Paramedicine Board sees advanced practice paramedics working and does not detail areas of practice.

To address this, the AMA proposes further consultation on the 'speciality' areas these practitioners will fit into, as well as the development of appropriate registration standards that outline defined categories for their practice. For example, settings such as emergency/critical care and primary care each have detailed competency standards, training requirements, and ongoing professional development. Prescribing rights should be explicitly linked to these categories through a structured formulary within a medically led care model, ensuring advanced care paramedics prescribe only within areas where they have verified expertise. This approach promotes safe, consistent, and accountable prescribing while supporting effective integration into the healthcare system.

Clear credentialing for advanced practice paramedics in primary care settings must be considered, along with the development and use of clinical governance tools and frameworks. Movement into a new area brings increased uncertainty and responsibility. If mishandled, it can fragment patient care and risk unintended consequences for the patient.

Proposed professional capabilities

Do the proposed capabilities identify the minimum knowledge, skills and professional attributes for safe and competent practice as an advanced practice paramedic? If no, please provide details.

The domains in the professional capabilities document reflect those of a very senior clinician, and the AMA is concerned the proposed capabilities far exceed the level of training and registration requirements suggested for an advanced practice paramedic. These capabilities are what is required of a medical practitioner. It is concerning that the proposal to regulate advanced practice paramedics is adopting such a medically driven approach, with requirements that reflect what a doctor would typically undertake in their daily practice.

Is the content, language and structure of the proposed capabilities clear, relevant and workable? If no, please describe why.

The AMA agrees with the statement: "The professional capabilities for advanced practice paramedics provide for practitioners to recognise when expertise needed is outside their scope of practice and collaborate with or refer to other health practitioners. A collaborative interprofessional approach proposes to improve timely access to care without compromising patient safety or outcomes." This must be made more apparent and transparent in the capabilities document. A well-functioning transdisciplinary and multidisciplinary team cannot function without each member understanding and abiding by this fundamental principle.

Is there any content that needs to be changed, added or removed in the proposed capabilities? If yes, please provide details.

See above.

Do you have any other feedback about the proposed capabilities?

See above.

Contact

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