

Submission to:
Legislative Council Sessional Committee
Government Administration A



**Inquiry into the Financial and Operational
Performance of the Department of Health:**

The underutilised efficiency benefits of Paramedicine

September 2026

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“Empowering paramedics to do more, expanding care pathways, and addressing long-stay drivers such as access to aged care and disability supports” is how one earlier independent submission to this Inquiry described the sustainable solution to ambulance ramping and operational performance issues.*

This submission sets out how to do that.

***Sphere Management Advisers + Consultants
GAA/FPH Submission 5, 8 April 2026**

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Executive Summary

Tasmania's health system is gridlocked and expensive. As the Australian Medical Association (AMA) Tasmania has described, hospitals are “constipated”: patients wait in ambulance queues because Emergency Departments (EDs) are full, EDs are full because inpatient beds are blocked, and beds are blocked by patients who no longer need acute care. The Department of Health estimates this congestion has already cost hundreds of millions of dollars and will reach \$461 million over the Budget and Forward Estimates.

This submission highlights an often overlooked issue: one of the Department's key operational performance indicators, the Transfer of Care KPI, explicitly measures the time to move a patient from paramedic care to ED care. Paramedics sit at the very interface the Inquiry is examining, yet Tasmania has no Chief Paramedic Officer (CPO) and no senior leadership voice for paramedicine. Other jurisdictions like Victoria, the Northern Territory and South Australia have already recognised this gap.

The author draws together the evidence from the Department, the independent cost data assembled by policy analyst Martyn Goddard, the operational views provided by the AMA Tasmania, the RACGP Tasmania and Sphere Management Advisers + Consultants (Sphere MAC). Other sources are the author's research into community paramedicine, including submissions to the Productivity Commission and the Australian Senate Rural and Regional Affairs and Transport References Committee. Reference is also made to previous submissions to the Tasmanian Legislative Council Sessional Committee Government Administration A and Tasmanian Health Department.

The evidence shows that paramedic-led community and primary care models can reduce ED presentations, lower hospital admissions, improve patient flow, and deliver measurable system-wide savings. Contemporary research indicates lower ambulance operating costs and significant net benefits per patient encounter. International and interstate precedents reinforce these findings. Tasmania already has the paramedicine workforce. What is missing is the leadership, visibility, and system integration required to deploy this workforce strategically.

This submission recommends eight practical evidence-based reforms that directly address the Inquiry's Terms of Reference and align with the National Health Reform Agreement's objectives of delivering care in the most appropriate setting and reducing avoidable hospital use:

1. Establish a Chief Paramedic Officer (CPO).
2. Expand and evaluate community paramedicine initiatives.
3. Include paramedicine in overall health workforce planning.
4. Make paramedicine visible in patient flow and performance data, e.g. include hospital-avoidance and non-conveyance indicators in the Health System Dashboard and Service Plan.
5. Integrate Ambulance Tasmania data into the Statewide Integrated Operations Centre (SIOC).
6. Add paramedicine to the Financial Sustainability Program as an efficiency lever.
7. Include paramedicine in any independent health system review.
8. Support national reforms for a Commonwealth CPO and Medicare recognition.

A central recommendation is that Tasmania establish a CPO, following the precedents set by Victoria and the Northern Territory, and the South Australian Government's firm commitment. It should then use that role to design, implement and evaluate paramedic-led models of community and primary care that the evidence suggests can efficiently reduce demand.

Consent is given for publication of this submission with the author's name in accordance with the Committee's usual processes but without specific contact details. The author thanks the Committee for its consideration, and would welcome the opportunity to provide further information if needed.

The author and this submission

1. The author is Adjunct Associate Professor Ray Bange OAM. He is an experienced health policy advisor, an Executive Committee member of the Australian Health Care Reform Alliance, and the recipient of an Order of Australia Medal for contributions to paramedicine, education and the community.¹ He publishes on paramedicine and health workforce policy as The Paramedic Observer and curates the social media posts of the Australian Health Care Reform Alliance.²
2. This submission is made in a personal capacity and does not represent the views of any organisation with which the author is or has been affiliated. Several submissions already before the Committee and available in the public domain at the time of writing were accessed in developing the submission,³ as well as independent analysis of data on ambulance services, paramedic registrants and research on Ambulance Tasmania paramedic operations.⁴
3. The submission addresses the Committee's Terms of Reference and also draws on the author's own recent advocacy. This includes a September 2025 submission to the Productivity Commission's inquiry into Delivering Quality Care More Efficiently, a March 2026 submission into Medicare Support for Rural, Regional and Remote Health, and a supplementary brief provided to the Senate Rural and Regional Affairs and Transport References Committee on 5 August 2026.⁵ It also builds on earlier submissions to the Tasmanian Legislative Assembly Committee on rural and remote health service delivery.⁶ Particular acknowledgement is made of the research of paramedic doctoral candidate and Westpac Scholar Matt Wilkinson-Stokes PhD(c).
4. This submission does not repeat that material. Instead, it draws a connection between those findings and the financial and operational performance problems that have been well documented through numerous inquiries that focus on a single point in the patient journey: the interface between the ambulance service and the hospital ED. It also speaks for a workforce that Tasmania has recognised but never given a dedicated clinical leadership voice, unlike Victoria and the Northern Territory and envisioned for South Australia.
5. The submission's central contention is that a Tasmanian Chief Paramedic Officer (CPO), and the paramedic-led primary care and prevention models that role would be positioned to build, is a concrete, evidence-based efficiency measure the Committee can recommend with confidence.

¹ R Bange, *Delivering Quality Care: Response to the Interim Report of the Productivity Commission*, submission to the Australian Government Productivity Commission, September 2025, 'The author', para 1. See Productivity Commission, *Delivering quality care more efficiently*: <https://www.pc.gov.au/inquiries-and-research/quality-care/>.

² The Paramedic Observer, Ray Bange OAM: <https://paramedprof.com/>.

³ Legislative Council Sessional Committee Government Administration A, Terms of Reference, Inquiry into the Financial and Operational Performance of the Department of Health, 17 December 2025: https://www.parliament.tas.gov.au/_data/assets/pdf_file/0032/107789/gaa.fph.adm.251217.TOR.jm.001.pdf See generally <https://www.parliament.tas.gov.au/committees/legislative-council/sessional-committees/govadmina/current-inquiries/inquiry-into-the-financial-and-operational-performance-of-the-department-of-health>

⁴ Sphere Management Advisers + Consultants, GAA/FPH Submission 5, 8 April 2026; AMA Tasmania, GAA/FPH Submission 7, 19 June 2026.

⁵ R Bange, *Delivering Quality Care: Response to the Interim Report of the Productivity Commission*, September 2025; Supplementary Brief to the Senate Rural and Regional Affairs and Transport References Committee, 5 August 2026. See generally https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport

⁶ R Bange, *Meeting the healthcare needs of rural Tasmanians*, March 2021, Rural Health Services Inquiry, Government Administration A Sub-Committee Legislative Council Sessional Committee, Parliament of Tasmania.

https://www.parliament.tas.gov.au/_data/assets/pdf_file/0026/55268/5420ray20bange20oam.pdf

See also *Supplementary Submission*, August 2021.

https://www.parliament.tas.gov.au/_data/assets/pdf_file/0028/57448/54b20supplementary20-20ray20bange.pdf

and Occasional Paper, *The ANZSCO Anomalies*, August 2022.

https://www.parliament.tas.gov.au/_data/assets/pdf_file/0030/59196/22082420ray20bange20the20anzsco20anomalies20augus202022.pdf

Section 1: A congested system with little reference to paramedicine

6. The Department's submission and that of AMA Tasmania independently corroborate a description of the congestion problem, even where they differ on the remedy. The Department reports that Tasmania had an average of 68 stranded long-stay patients in 2023-24, rising to 88 in 2024-25 (a direct cost of \$132 million over the two years), climbing further to 108 in the first quarter of 2025-26, with a projected cost of \$461 million over the Budget and Forward Estimates.⁷ Patients with moderate to severe multimorbidity and frailty, making up fewer than 10,000 people, or 1.7 per cent of the Tasmanian population in 2025, occupied 40 per cent of admitted overnight acute beds, at an estimated cost of \$370 million.⁸
7. AMA Tasmania describes the consequence of this in practical terms: the system is, in its words, constipated.⁹ Its account of the chain of care runs from the hospital front door inward: *"ambulances wait because emergency departments are full; emergency departments are full because admitted patients cannot access inpatient beds; inpatient beds are full because patients cannot be discharged safely"*, and so on through surgery, outpatients and long-stay patients.¹⁰ The publicly reported KPIs bear this out: in 2024-25, only 47.5 per cent of ED patients were admitted, referred or discharged within four hours against a target of 90 per cent or more, and the average overdue wait for elective surgery reached 175 days for Category 2 and 183 days for Category 3 patients, against targets of 32 and 39 days respectively.¹¹
8. What is notable is where the Department locates the start of that chain of care. Its submission explains that the Transfer of Care KPI – *"the measure of time taken for transfer of clinical care of patients from paramedics to emergency department staff"* – is *"influenced by a lack of inpatient bed capacity, which is in part attributable to the delayed discharge of patients who are medically ready for discharge"*.¹²
9. The Department's account of that key operational KPI names paramedics as a key part of the activity being measured, yet nowhere in the 29-page submission covering financial performance, operational performance, budgetary control and clinical governance does the Department identify a senior paramedicine clinical or operational voice.
10. Its Statewide Clinical System Governance Committee is described in detail, with functions spanning clinical policy, risk and quality across public, private, and community health services, but no paramedicine leadership role is mentioned.¹³ This is consistent with Tasmania having no CPO.

⁷Department of Health, GAA/FPH Submission 4, March 2026, s.2.3, https://www.parliament.tas.gov.au/__data/assets/pdf_file/0017/103364/4.-Department-of-Health_Redacted.pdf.

⁸Department of Health, GAA/FPH Submission 4, March 2026, s.1, s.2.3.

⁹AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.1, https://www.parliament.tas.gov.au/__data/assets/pdf_file/0021/107814/7.-Australian-Medical-Association-Tasmania_Sanitised.pdf.

¹⁰AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.5.

¹¹AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.9, citing Treasury Tasmania Budget Papers.

¹²Department of Health, GAA/FPH Submission 4, March 2026, s.3.2.

¹³Department of Health, GAA/FPH Submission 4, March 2026, s.3.5.

Section 2: A workforce identified by others

11. The author has raised the issue of paramedicine engagement in previous submissions and is not the first to mention paramedicine with the current Inquiry. Sphere MAC's submission 5, addressing operational performance directly, says plainly:¹⁴

"...when a system experiences operational performance issues such as ambulance response delays and ramping, simply purchasing more ambulances or employing more paramedics does not resolve the underlying issues. It increases cost, labour and complexity, often with no improvement in outcomes. International experience shows that sustainable solutions come from understanding patient conveyance patterns, empowering paramedics to do more, expanding care pathways, and addressing long-stay drivers such as access to aged care and disability supports."

12. These measures respond to Tasmania's limited specialist workforce availability, and constrained local capacity across some specialties.¹⁵ The author agrees with that diagnosis. The same service-transition logic applies to paramedicine, but at a different point in the patient journey.
13. This submission sets out an evidence-based pathway for using paramedics to lift the efficiency of healthcare in Tasmania, by taking an existing workforce close to the patient, and mobilising its scope of practice to expand access to care before defaulting to hospital-based care.¹⁶
14. AMA Tasmania similarly identifies the measures needed to improve patient flow, including increased subacute capacity, expanded Hospital in the Home and Care@home, better hospital-to-home packages, and stronger clinical leadership of flow and bed management¹⁷ to sit directly on top of programs the Department has already begun.
15. The Department confirms that Care@home expanded its model of care throughout 2025 to include the Chronic Disease Management Program, covering diabetes, heart failure, chronic obstructive pulmonary disease and post-COVID syndrome (Long COVID).¹⁸ This is a patient cohort for which contemporary community paramedicine provides a basis for paramedic-led assessment and community-based care, including through appropriately governed extended-scope models.

Section 3: Exploring Tasmania's paramedicine workforce

16. Discussion of Tasmania's health workforce has concentrated on medicine and nursing as the traditional health providers. That focus overlooks paramedicine as a medium-sized and growing registered health profession. Registration data from the Paramedicine Board of Australia shows 27,809 registered paramedics nationally at the end of March 2026, growing at around five per cent annually.¹⁹ Tasmania had 804 registrants as at 31 March 2026, of which female registrants comprised 50.5%.

¹⁴ Sphere Management Advisers + Consultants, GAA/FPH Submission 5, 8 April 2026, 'Demand for Care and Operational and Financial Performance', https://www.parliament.tas.gov.au/_data/assets/pdf_file/0020/104906/5.-Sphere-Management-Advisers-Consultants_Redacted.pdf

¹⁵ Department of Health, GAA/FPH Submission 4, March 2026, s.2.3.

¹⁶ Paramedicine terminology is confusing, and where reference is made to community paramedics the context is important for interpretation. A community paramedic refers generically to a paramedic with specific training to work in community and primary care settings. See Matt Wilkinson-Stokes, Robbie King, *Beyond 42 titles: a capability-based approach to standardising 'community paramedic' terminology*, International Paramedic Practice, VOL 16, NO 2, July 2026. <https://doi.org/10.12968/ippr.2025.0016>

¹⁷ AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.5.

¹⁸ Department of Health, GAA/FPH Submission 4, March 2026, s.2.3.

¹⁹ R Bange, *Delivering Quality Care*, September 2025, para 20, citing Paramedicine Board of Australia, Quarterly Registrant Statistics.

17. A growing share of the paramedicine workforce sits outside the jurisdictional ambulance services. Analysis of Paramedicine Board of Australia statistics against the Productivity Commission's annual Report on Government Services indicates that, as at June 2024, roughly 30 per cent of registered paramedics nationally did not work for a publicly funded ambulance service, instead working in industry, urgent care, aged care, event, aeromedical, community and primary care roles.²⁰ A similar situation (30.9%) obtains for June 2025 (Figure 1).²¹
18. By March 2026, this often forgotten group had grown to well over 8000 persons nationally. National and state health workforce planning has little visibility of this cohort. An example is the Victorian CP@clinic program, whose paramedics are employed by community health services rather than a jurisdictional ambulance service.²²
19. This is not a unique Tasmanian blind spot. Rural Workforce Agency Victoria published its Rural Health Workforce Census for 2025–26 in August 2026, surveying 708 general practitioners, nurses and midwives, allied health professionals and specialists. Despite Victoria having had a CPO since 2017, the Census does not mention paramedics, paramedicine or ambulance services once across 31 pages,²³ and its discussion of data limitations does not identify paramedicine as an Australian Health Practitioner Regulation Agency registered allied health profession. Having a CPO does not guarantee that a jurisdiction's workforce planning will see paramedics, and Recommendation C is framed to build that visibility into Tasmania's system from the outset.

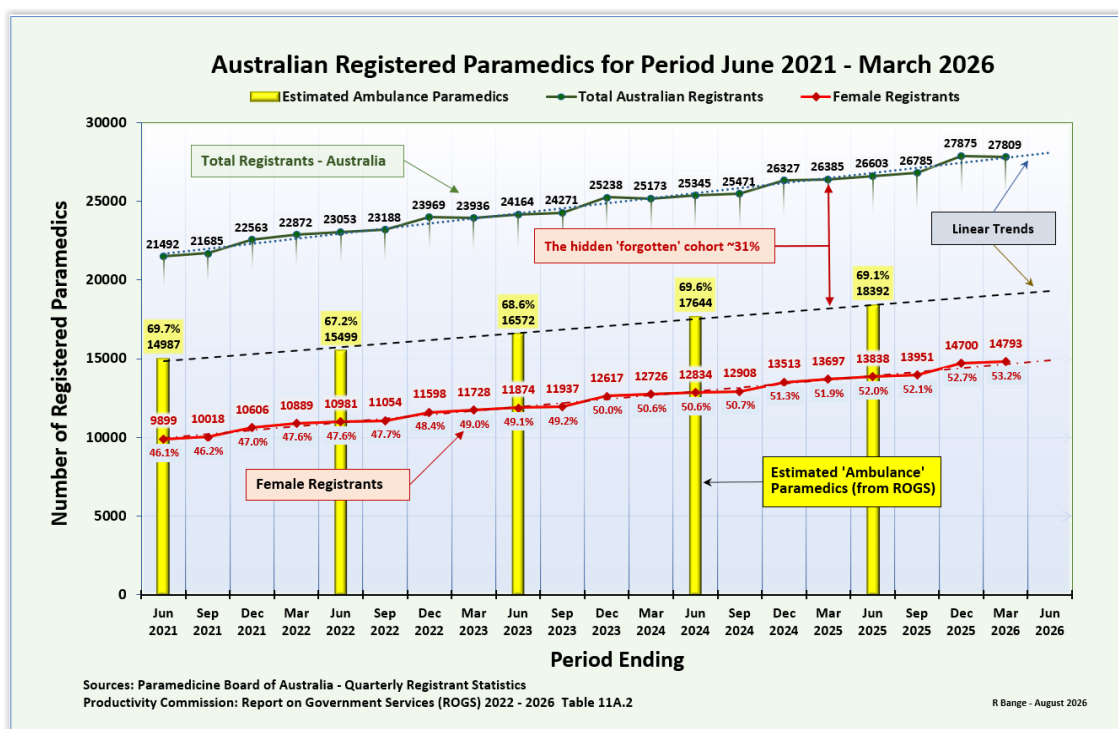


Figure 1 Paramedic registrants in Australia 2021 – 2026

²⁰ R Bange, *Delivering Quality Care*, September 2025, para 21, citing Productivity Commission, Report on Government Services 2025, Part E, Table 11A.2.

²¹ R Bange, *Report on Government Services (RoGS) 2026*, The Paramedic Observer, Facebook 23 February 2026. <https://tinyurl.com/7ekubxh9> Accessed 03/09/2026.

²² G Agarwal, G Mahal, R Angeles et al, *Community Paramedics in Australia: A Case Study Adapting the Canadian Community Paramedicine at Clinic (CP@clinic) Program in Rural Australia, Using an Implementation Science Approach*, Journal of Primary Care & Community Health (published online 20 August 2026) <https://journals.sagepub.com/doi/full/10.1177/21501319261478071>

²³ Rural Workforce Agency Victoria, *Victorian Rural Health Workforce Census 2025–2026: Shaping the future of rural health in Victoria*, August 2026, pp.5–9, 31. https://rwav.com.au/wp-content/uploads/2026/08/Victorian-Rural-Health-Workforce-Census-2025-2026_2.pdf Accessed 24/08/2026.

20. The author's personal experience illustrates how paramedicine can be excluded from mainstream health workforce planning by default. In 2024, initial advice provided in respect of a \$77.35 million Commonwealth Grant Opportunity for Primary Health Network commissioning of multidisciplinary teams was that paramedics were not eligible professionals. Only after direct intervention by the author at a senior level did the Commonwealth Department confirm that paramedics were eligible to be commissioned as allied health practitioners, with the issue of a specific update to its guidelines.²⁴
21. Without a nominated senior paramedicine officer providing overall leadership inside the Department, similar omissions in Tasmanian workforce and funding frameworks are likely to go unnoticed until a patient, a program or a budget is affected.
22. It is also a mistake to think of paramedics as being engaged only in emergency response.²⁵ National ambulance sector data show that emergency responses have consistently accounted for less than half of total ambulance responses over the past decade, with urgent and non-emergency responses making up the balance.²⁶ Jurisdictional response patterns vary, and Figure 2 shows the response pattern for Tasmania, which is broadly representative, albeit marginally higher (50.4%) than the national average (47.6%) in 2024-25.

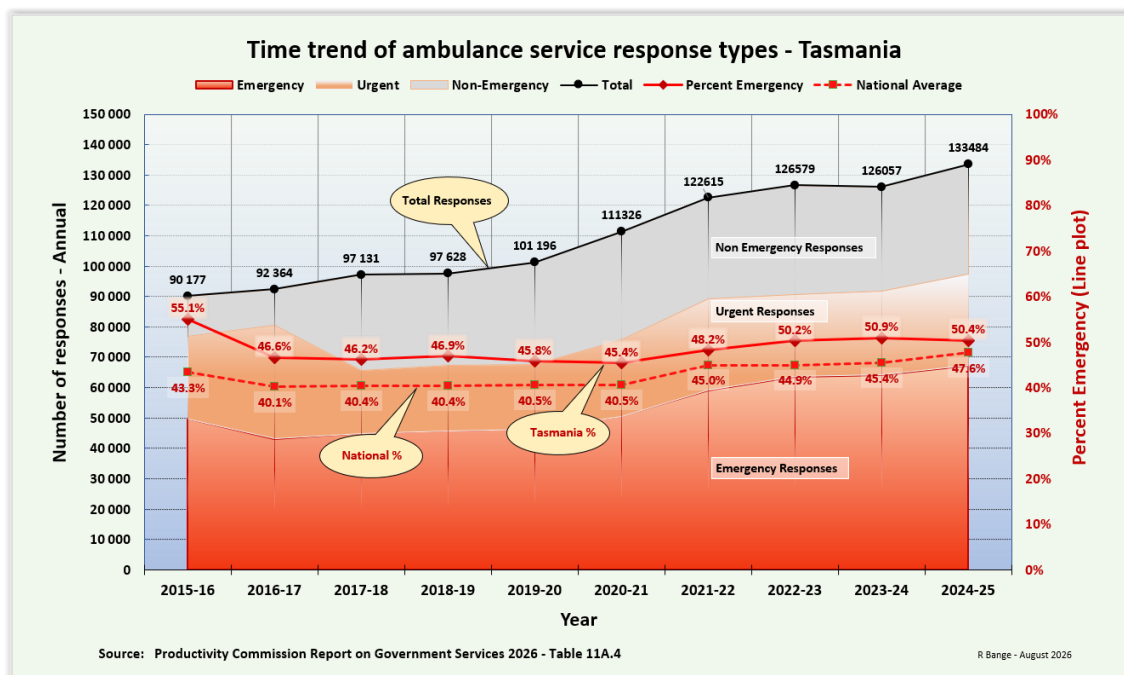


Figure 2 Time trend of Ambulance Tasmania responses

23. Ambulance Tasmania's Transfer of Care KPI, discussed in Section 1, shows that a large share of paramedic activity already sits at the boundary between emergency and non-emergency care, which is the interface at which the community paramedicine models discussed later in Section 4 are designed to operate.

²⁴ R Bange, *Delivering Quality Care*, September 2025, para 16, citing R Bange, *Forgotten, omitted, overlooked, or excluded – but certainly missing*, Facebook, The Paramedic Observer, 15 April 2024. <https://tinyurl.com/yt88mh98> Accessed 08/09/2026.

²⁵ Tavares, W., Strum, R.P., Henderson, L. et al. *Examining the alignment between an intervention-based paramedic model of care and 9-1-1 utilization*. BMC Health Serv Res 26, 1127 (2026). <https://doi.org/10.1186/s12913-026-14890-8> Accessed 08/09/2026.

²⁶ R Bange, Report on Government Services (RoGS) 2026, The Paramedic Observer, Facebook, 23 February 2026, citing Report on Government Services 2026, Productivity Commission, Table 11A.4. <https://tinyurl.com/56tv6vwc> Accessed 24/08/2026.

Section 4: The value paramedicine can deliver

24. The National Health Reform Agreement (NHRA)²⁷ establishes shared Commonwealth–state responsibility for funding health care focused on patient outcomes. Key NHRA objectives include:
- Delivering the right care in the most appropriate setting;
 - Improving system efficiency and sustainability;
 - Reducing avoidable hospital admissions and demand;
 - Preventing cost shifting between jurisdictions; and
 - Establishing activity-based funding to discourage inefficient care pathways.
25. The absence of paramedicine from Medicare creates a structural funding misalignment with those objectives at a time of declining funding.²⁸ Because paramedics currently are not Medicare-billing practitioners, their engagement in primary and urgent care settings requires additional (or inefficient) eligible practitioner involvement or a direct patient charge. For ambulance responses where patients are safely treated and managed in the community, the absence of Medicare reimbursement means either a significant patient fee or a jurisdictional absorption of costs.
26. A simplified conceptual representation of patient interactions and payment arrangements is shown in Figure 3. When preventive care is delayed, or access to care is not funded by Medicare, it potentially impacts jurisdictions that are responsible for the funding of ambulance responses, ED presentations, short stay admissions, and diagnostics - costs that could often be minimised through appropriate community-based paramedic interventions.

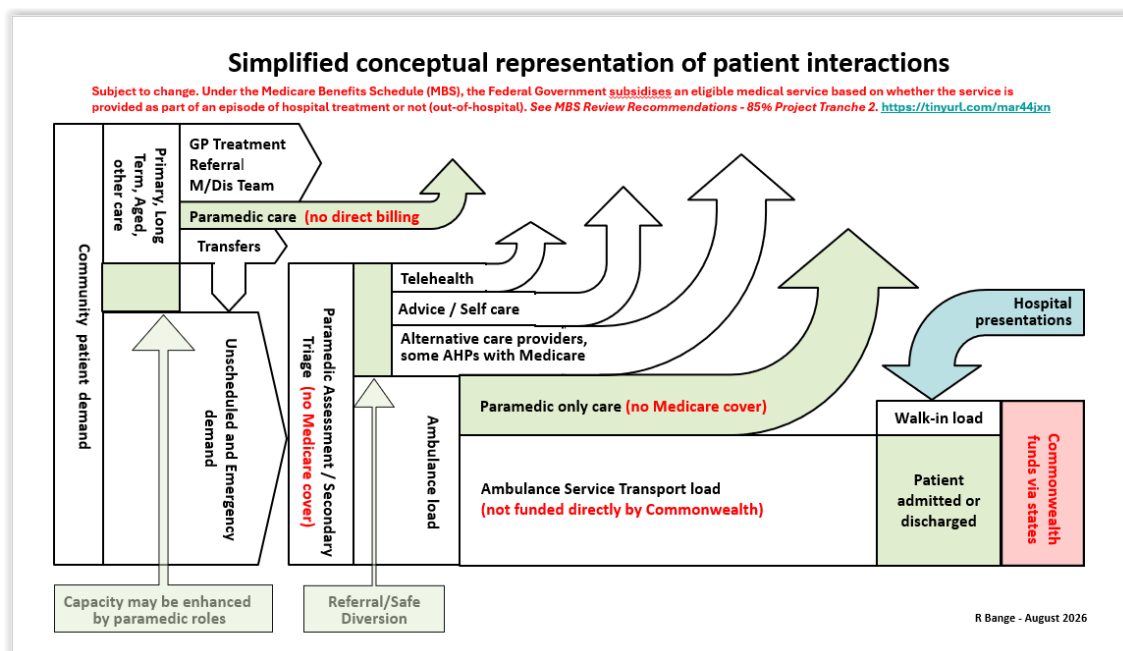


Figure 3 – Conceptual representation of patient interactions and payment

27. The result can be cost shifting rather than genuine cost containment. This increases activity-based hospital costs and places avoidable stress on ED capacity. Medicare’s current design, which doesn’t include paramedics as eligible providers, and funding arrangements that don’t recognise ambulance service activities, thus work against, rather than with, NHRA efficiency goals.

²⁷ Addendum to the National Health Reform Agreement (2026–2031), Council on Federal Financial Relations: <https://tinyurl.com/mr434ux5> Accessed 18/08/2026.

²⁸ R. Chomik, S. M. Bates, and M. Wright, *Two Decades of Primary Care Funding in Australia: A Descriptive Time-Series and Distributional Analysis*, Medical Journal of Australia 224, no. 6 (2026): e70210, <https://doi.org/10.5694/mja2.70210>

28. Better recognition of ambulance service contributions to primary care is needed, as well as funding of expanded paramedic roles that link ambulance and other health services to provide integrated care. This view is reinforced by contemporary evidence
29. A prospective, controlled, quasi-experimental, observational cost-benefit analysis compared community paramedics with typical ambulance-based care for non-emergency '000' callers. The study was conducted over 22 consecutive days in April 2025 in Australian Tasmania which had a 2024-2025 budget of ~A\$200 million, 400 paramedics, 88,000 requests per year, and serves a population of ~575,000.²⁹ Fifty-two patient presentations were analysed. ED transportation was 37 per cent lower, in relative terms, in the community paramedic group.
30. Combining costs and consequences across the healthcare system and patient perspectives, community paramedics were associated with an estimated net benefit of \$3,281 per presentation (95%CI -\$41 to \$7,257). While the confidence interval crossed zero and statistical significance was not achieved for the primary outcomes, reflecting the study's limitations, the intervention was cost-beneficial in 97 per cent of 10,000 bootstrap resamples.³⁰ These results are encouraging, but a larger trial is needed to confirm a more exact cost-benefit ratio.
31. Patients valued the model positively: mean willingness-to-pay was \$144, with reasons clustering around avoiding the ED, the available clinical expertise, interpersonal strengths, convenience, speed, and reassurance.³¹ These findings align with data from Reports on Government Services.
32. One further finding is directly relevant to budgetary control. Ambulance service costs were lower under the community paramedic model, with mean savings generated by the reduction in seven-day re-presentation costs to the ambulance or public ED (64% of ambulance savings, as there were 14% fewer re-presentations). Clinician costs were lower at 13% (one paramedic attending with a modestly higher salary in place of a two-officer crew), as were vehicle costs at 25% (a minivan rather than a stretcher ambulance). The savings did not come from removing frontline capacity, but from using a different, fully staffed model of frontline capacity.³²
33. The dominant driver of these savings was reduced inpatient admission – 67 per cent of total healthcare system savings (\$2,069 of \$3,093 per presentation) – as the admission rate fell by around half under the community paramedic model, directly speaking to the 'stranded patient' and bed-access pressures highlighted in the Executive Summary of this submission.³³ Assuming a similar case mix and effectiveness, the study outcomes extrapolated across the 4,093 patients seen by the service's community paramedics in the preceding year, estimated a potential benefit of \$13.4 million (95%CI -\$0.2 million to \$29.7 million) compared to usual care.³⁴
34. This study appears to be the first Australian economic evaluation of community paramedicine responding to non-emergency '000' calls and is believed to be the first anywhere to measure patient-borne costs. The outcomes mirror savings from Canadian data.³⁵ The author makes no claim that the monetary figures would transfer unchanged to more general application in Tasmania. However, it is the best available contemporary evidence of potential benefits, and the basis for Recommendation B that Tasmania enhance its commitment to this model of care.

²⁹ Wilkinson-Stokes et al., *Cost-benefit analysis of community paramedics in an ambulance service* (2026), Australasian Emergency Care. <https://doi.org/10.1016/j.auec.2026.08.003> Accessed 05/09/2026.

³⁰ Ibid., Results, Cost-benefit analysis.

³¹ Ibid., Results, Consequences (Willingness-to-Pay).

³² Ibid., Results, Costs.

³³ Ibid., Discussion.

³⁴ Ibid., Results, Cost-benefit analysis.

³⁵ Gina Argarwal et al., *Cost-effectiveness analysis of a community paramedicine programme for low-income seniors living in subsidised housing: the community paramedicine at clinic programme (CP@clinic)*, *BMJ Open* 2020;10:e037386. [doi: 10.1136/bmjopen-2020-037386](https://doi.org/10.1136/bmjopen-2020-037386)

35. Tasmania would not be alone in adopting this approach. England's National Health Service (NHS) has funded paramedics as part of the core general practice team since 2019 through its Additional Roles Reimbursement Scheme (ARRS) on the basis that it enriches the clinical skill mix available to a practice and allows general practitioners to work at the top of their scope.³⁶
36. Within Australia, Victoria established Australia's paramedic practitioner roles in February 2024 and, together with Victoria University, committed \$20 million to establish a Centre of Excellence in Paramedicine, opening in 2026.³⁷ New Zealand's Director-General of Health has approved a schedule of 232 medicines for designated paramedic prescribers,³⁸ with the enabling Medicines Regulations coming into force on 3 September 2026.³⁹
37. South Australia's community paramedicine program at Ceduna and the Victorian CP@clinic program offer other directly comparable Australian models that Tasmania could draw on.⁴⁰ CP@clinic has scaled from a single 2022 pilot site in Mildura to four sites across 35 locations, serving approximately 676 active participants by 30 June 2025, using the Institute for Healthcare Improvement's *'Framework for Going to Full Scale'* to structure the expansion.⁴¹ As another indication of value, the program's underlying Canadian model was associated with a 20 per cent reduction in emergency 9-1-1 call volume in a controlled evaluation.⁴²
38. These precedents provide Tasmania with several contemporary regulatory templates to draw on alongside the UK's established ARRS model.

Section 5: The Department's sustainability program uses one lever

39. The Minister for Health's response to this Committee's Questions on Notice shows that, of the \$33.713 million in budget efficiency savings achieved in the year-to-date to 31 March 2026, \$10.592 million came from reducing agency nursing, \$5.25 million from a nurse roster review, \$3.203 million from reduced overtime, \$2.339 million from reduced casual FTE, and \$1.125 million from medical locum savings. That total of more than \$22.5 million, or roughly two-thirds of the entire savings task, came from changes to the existing nursing and medical workforce.⁴³
40. Locum and agency reliance is a material cost. Independent policy analyst Martyn Goddard's submission found that Tasmania spent \$105,739,782 on locum doctors and \$76,858,441 on agency nurses in 2023-24 – a combined \$182,598,223 in a single year.⁴⁴

³⁶ R Bange, *Delivering Quality Care*, September 2025, para 71.

³⁷ Premier of Victoria, *'Australia's First Paramedic Practitioners One Step Closer'*, 19 February 2024, cited in R Bange, *Delivering Quality Care*, September 2025, para 36 and footnote 32; Bange R, *'Victoria University Centre of Excellence in Paramedicine'*, The Paramedic Observer, 2 February 2024, <https://paramedprof.com/>.

³⁸ RNZ News, *Paramedics will soon be able to prescribe certain medicines*, 6 June 2026.

<https://www.rnz.co.nz/news/political/597421/paramedics-will-soon-be-able-to-prescribe-certain-medicines> Accessed 24/08/2026.

³⁹ NZ Ministry of Health, *Specified medicine list for paramedic prescribers*, 19 August 2026.

<https://www.health.govt.nz/news/specified-medicines-list-for-paramedic-prescribers> Accessed 31/08/2026.

⁴⁰ E Spelten et al, *'Community Paramedicine in Australian community health – Implementation of the CP@CLINIC program'*, La Trobe University, 26 February 2023, cited in R Bange, *Delivering Quality Care*, September 2025, para 62.

⁴¹ G Agarwal, G Mahal, R Angeles et al, *Community Paramedics in Australia: A Case Study Adapting the Canadian Community Paramedicine at Clinic (CP@clinic) Program in Rural Australia, Using an Implementation Science Approach*, Journal of Primary Care & Community Health (published online 20 August 2026) doi:10.1177/21501319261478071.

⁴² G Agarwal, R Angeles, M Pirrie et al, *Reducing 9-1-1 Emergency Medical Service Calls By Implementing A Community Paramedicine Program For Vulnerable Older Adults In A Community In Public Housing in Canada: A Multi-Site Cluster Randomised Controlled Trial*, Prehospital Emergency Care 2019; 23(5): 718–729.

⁴³ Minister for Health, Mental Health and Wellbeing, response to Questions on Notice, 15 May 2026, Table 5,

https://www.parliament.tas.gov.au/_data/assets/pdf_file/0026/107792/260515-Minister-for-Health-QON-Response.pdf

⁴⁴ M Goddard, GAA/FP Submission 6, 15 July 2026, https://www.parliament.tas.gov.au/_data/assets/pdf_file/0020/107813/6.-Martyn-Goddard_Redacted-and-Sanitised.pdf

41. The Department's Financial Sustainability Program includes reducing locum usage, optimising workforce productivity, rationalising diagnostics usage, enhancing NHRA revenue, and reforming rostering practices,⁴⁵ but contains no reference to better utilising paramedicine as a demand-management lever. This is despite the Department naming paramedics as part of its principal operational KPI. While the Program is working on the supply side of medical and nursing workforce cost, the demand-side lever identified independently by Sphere MAC and supported by the evidence in Section 4 goes underutilised.
42. That gap sits alongside a funding vehicle the Commonwealth has already built for this kind of reform. Of the \$900 million National Productivity Fund, \$60 million is earmarked as a scope-of-practice incentive for jurisdictions that remove unwarranted practice restrictions. The Australian College of Nursing has highlighted that the implementation is currently directed at expanding nurse prescribing.⁴⁶ It has called for changes to federal health funding arrangements, arguing nurse practitioner-led clinics remained unable to register for MyMedicare or access practice incentives available to GP-owned clinics. A similar Medicare situation applies for paramedicine.
43. More seriously, paramedicine remains absent from these reforms, despite Productivity Commission modelling suggesting health sector scope-of-practice reform of this kind could deliver almost \$300 million a year in budget savings and boost GDP by up to \$1.2 billion annually.⁴⁷
44. AMA Tasmania makes a related point about the medical workforce, stating that recruitment and retention require competitive employment conditions, respectful clinical leadership, better governance, and meaningful clinician engagement, and cannot be achieved *"by simply cutting budgets while asking an already depleted workforce to do more"*.⁴⁸
45. The same logic applies to paramedicine, which, unlike medicine and nursing, has no seat in the clinical governance structure, and is unable to advocate for better patient care through its own workforce redesign in the way other clinical professions can. This may be compounded by inflexible ambulance-service employment conditions: the Australian CP@clinic rollout documented paramedics being unable to retain permanent part-time contracts with their ambulance service as a specific barrier to recruiting and retaining community paramedics.⁴⁹

Section 6: A Chief Paramedic Officer: leveraging best practice

46. Establishing a CPO would not place Tasmania ahead of national reform. Rather, this step would bring Tasmania into line with jurisdictions that have already adopted the position. Victoria has had a CPO since 2017, and the Northern Territory appointed its first CPO in early 2025. The Territory now maintains a standing Office of the Chief Paramedic providing professional, clinical and ethical leadership for paramedic practice across NT Health. South Australia has already committed to establishing a Chief Paramedic Officer, extending the national trend to a third jurisdiction. The annual conference of the Australian Capital Territory Labor Party formally adopted the appointment of a CPO as policy on 29 August 2026, thereby informing government policy for that jurisdiction.

⁴⁵ Department of Health, GAA/FPH Submission 4, March 2026, s.4.2.1.

⁴⁶ Health Services Daily, *Nurses urge states to grab \$60m scope-of-practice incentive*, 18 August 2026.

<https://www.healthservicesdaily.com.au/nurses-urge-states-to-grab-60m-scope-of-practice-incentive/51082> Accessed 24/08/2026.

⁴⁷ ADVOC8, *Treasurers Agree to Productivity Enhancing Reforms*, 14 August 2026. https://www.advoc8.co/shared-content/?share=https://app.advoc8.co/public/feeds_v2/media_releases/NMTbOwP?forwarded_params= Accessed 24/08/2026.

⁴⁸ AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.10, s.14.

⁴⁹ G Agarwal, G Mahal, R Angeles et al, *Community Paramedics in Australia: A Case Study Adapting the Canadian Community Paramedicine at Clinic (CP@clinic) Program in Rural Australia, Using an Implementation Science Approach*, Journal of Primary Care & Community Health (published online 20 August 2026) doi:10.1177/21501319261478071

47. This appointment is also supported nationally by the paramedicine profession's peak body. The Australasian College of Paramedicine's Position Statement on Chief Paramedic Officers outlines that senior paramedicine clinical leadership is a necessity in health systems that seek to make full use of the profession's capabilities.⁵⁰

48. The CPO role is strongly supported by the national union movement.⁵¹

“ACAU is committed to advocating for the establishment of Chief Paramedic positions as a matter of urgency in all Australasian jurisdictions. We believe Chief Paramedics should provide the professional link between Ministers, the Chief Executives of Health, Community and Emergency services and the paramedic workforce across jurisdictions. Chief Paramedics will have an important role providing high-level advice and leadership on paramedic professional, workforce and policy matters. We believe the appointment of Chief Paramedics has the potential to champion the integration of paramedics into primary health care, help realise significant economies in health budgets and most importantly enhance the provision of patient-centred care”

ACAU 2022 Position Statement #2 – Chief Paramedic Officers.⁵²

49. Tasmania has an ageing and highly dispersed population with a high prevalence of chronic and multiple morbidity. Its EDs cost 47.5 per cent more per presentation than the national average, and its acute wards 31.1 per cent more per separation. Yet it has neither a CPO nor an equivalent nominated clinical lead for paramedicine – a gap that Recommendation A, and the outline draft position description at Appendix B address directly.

50. This appointment is not a purely Tasmanian matter, and a Tasmanian CPO would be well placed to respond to issues at a national level. With roughly three in ten of Australia's registered paramedics working outside a jurisdictional ambulance service, these practitioners are engaged in diverse roles that state health workforce planning typically has little visibility of. A Tasmanian CPO would be positioned both to lead paramedic-led demand management inside the Department of Health (including consideration of Ambulance Tasmania), and to bring this broader cohort of the profession into jurisdictional workforce planning and governance for the first time.⁵³

Section 7: Governance: decentralisation and clinical leadership

51. Martyn Goddard's earlier submission to the Committee attributes a substantial part of Tasmania's excess hospital cost – \$630 million across six major expenditure categories in 2023-24 alone, including \$429 million in acute care and \$131 million in emergency care – to the reintroduction, from 2014, of centralised command-and-control decision-making. That reversed the one year, 2015-16, in which Tasmania's acute costs briefly matched the national average.⁵⁴

⁵⁰ Australasian College of Paramedicine, Position Statement: Chief Paramedic Officers, <https://paramedics.org/storage/news/Chief-Paramedic-Officers-Position-Statement-AUS.pdf>; see also <https://paramedics.org/news/chief-paramedic-officers-needed>.

⁵¹ Australasian Council of Ambulance Unions, *NSW needs an Independent Chief Paramedic Officer*, Facebook, 23 July 2026 <https://www.facebook.com/ambulanceactive/posts/pfbid0unmEpmjEmVs846xWCPoLyZSE94mVJjXryapfbFtGJoi3Kx7myig4xenDadnGT2SI> Accessed 24/08/2026.

⁵² Australasian Council of Ambulance Unions (ACAU), *Strategic Plan 2022*.

⁵³ R Bange, *What would a Chief Paramedic Officer do?*, Rural and Regional Affairs and Transport References Committee — Inquiry into Rural, Regional and Remote Medicare Access and Funding, Australian Senate, 5 August 2026. <https://www.aph.gov.au/DocumentStore.ashx?id=92bf42db-c584-4925-b2af-1bdc0ae892ef> Accessed 24/08/2026.

⁵⁴ M Goddard, GAA/FPH Submission 6, May and 15 July 2026.

52. A similar diagnosis, at the national level, was reached by the Grattan Institute in November 2025, which found public hospitals nationally could achieve substantial savings without affecting patient care through better-targeted, less centrally rigid budget and performance management.⁵⁵
53. The author does not accept every element of Mr Goddard's analysis, which concerns administrative and purchasing authority more broadly. It is, however, consistent with AMA Tasmania's own recommendation that the Department "*embed clinicians and other frontline clinical leaders in operational decision-making*" rather than leave it to central administration.⁵⁶
54. While this submission advocates for expansion of paramedic scope, it acknowledges that this requires appropriate clinical governance, ongoing training, and clear indemnity and accountability arrangements. A properly constituted CPO, with delegated clinical authority and professional support, rather than a purely advisory title, could extend that same principle to paramedicine - and at the same time strengthen accountability for a growing and increasingly complex scope of practice. The author notes that this provides a fraud and probity safeguard within the meaning of the Committee's fourth Term of Reference.⁵⁷

Section 8: Prevention: matching strategy to delivery mechanisms

55. The Department's submission notes that a consultation draft of its 20-Year Preventive Health Strategy was released in December 2025, which aims to reduce long-term demand on the health system by improving population health outcomes and addressing preventable chronic disease.⁵⁸ Community paramedicine is an evidence-based, proven delivery vehicle for exactly this kind of strategy in regional and rural Tasmania, where Ambulance Tasmania already maintains a presence that general practice and allied health cannot always sustain.
56. These are the same thin markets that Sphere MAC and RACGP Tasmania separately identify as structural features of the Tasmanian system,⁵⁹ and which the author (and others) raised in earlier submissions on rural and remote healthcare in 2021, 2022 and 2026.⁶⁰ The scale of unmet primary-care demand this can mask is significant: 36 per cent of CP@clinic attendees in the Australian pilot had no regular GP.⁶¹
57. The author has advocated for this case nationally, recommending to the Productivity Commission that any National Prevention Investment Framework explicitly fund community paramedicine programs and use evaluation tools capable of capturing their fiscal, equity and social benefits.⁶² A strategy without a designated workforce is an aspiration, but paramedicine with appropriate policies led by a CPO is available for implementation now.

⁵⁵ Peter Breadon, Elizabeth Baldwin, *Smarter spending: Getting better care for every hospital dollar*, Grattan Institute, November 2025. <https://grattan.edu.au/wp-content/uploads/2025/11/Smarter-Spending-Getting-better-care-for-every-hospital-dollar-Grattan-2025.pdf> Accessed 24/08/2026.

⁵⁶ AMA Tasmania, GAA/FPH Submission 7, 19 June 2026, s.11.

⁵⁷ Legislative Council Sessional Committee Government Administration A, Terms of Reference, 17 December 2025, item 4.

⁵⁸ Department of Health, GAA/FPH Submission 4, March 2026, s.3.1.

⁵⁹ Sphere Management Advisers + Consultants, GAA/FPH Submission 5, 8 April 2026, 'A Rapid Reflection on Where We Came from and Where We are Today'; RACGP Tasmania, GAA/FPH Submission 2, 13 March 2026, item 2.

⁶⁰ R Bange, *Medicare Support for Rural, Regional and Remote Health: A Paramedicine Perspective*, Rural and Regional Affairs and Transport References Committee, Australian Senate, March 2026. <https://www.aph.gov.au/DocumentStore.ashx?id=3fdce777-3d36-4029-8679-f6c02be00b3c&subId=787694> Accessed 24/08/2026.

⁶¹ G Agarwal, G Mahal, R Angeles et al, Community Paramedics in Australia: A Case Study Adapting the Canadian Community Paramedicine at Clinic (CP@clinic) Program in Rural Australia, Using an Implementation Science Approach, *Journal of Primary Care & Community Health* (published online 20 August 2026) doi:10.1177/21501319261478071

⁶² R Bange, *Delivering Quality Care*, September 2025, paras 81-82, response to Draft Recommendation 3.1.

Recommendations

The author proposes that the Committee make the following recommendations. Together, these measures provide Tasmania with a realistic, scalable pathway to reduce avoidable demand, improve operational performance, and strengthen financial sustainability:

Recommendation A: Establish a Tasmanian Chief Paramedic Officer

That the Tasmanian Government establish a Chief Paramedic Officer within the Department of Health, with a standing seat on the Statewide Clinical System Governance Committee alongside the Chief Medical, Nursing and Allied Health Officers, following the precedent set by Victoria and the Northern Territory, and the Government's commitment from South Australia, and consistent with the draft Position Statement at Appendix B.

Recommendation B: Pilot a funded community paramedicine model

That the CPO, once established, be tasked with designing and piloting a statewide funded community paramedicine and/or secondary-triage model targeting non-emergency '000' demand and the chronic-disease cohort already served by Care@home (diabetes, heart failure, COPD and Long COVID), informed by the contemporary Australian cost-benefit pilot outlined in Section 4 of this submission and by comparable Australian models such as Ceduna, the Northern Territory and CP@clinic (appropriately scaled using the Institute for Healthcare Improvement's Framework).

Recommendation C: Engage the whole paramedicine profession in workforce planning

That the Department incorporate registered paramedics working outside Ambulance Tasmania into health workforce planning and reporting and that the department integrate paramedicine into community care pathways by extending Care@home and Hospital in the Home referral pathways to include paramedic-led assessment, monitoring and community-based care.

Recommendation D: Make paramedicine's contribution to patient flow visible

That the Service Plan and Health System Dashboard be expanded to include paramedic-led hospital-avoidance and non-conveyance indicators, alongside the existing ambulance response time and Transfer of Care KPI, so that paramedicine's contribution to patient flow can be measured and held to account like every other part of the system.

Recommendation E: Complete the integration of Ambulance Tasmania data into SIOC

That the Statewide Integrated Operations Centre be directed to complete its stated intention of integrating real-time Ambulance Tasmania and community paramedicine data, with a named senior paramedicine officer as the accountable liaison pending the CPO's appointment.

Recommendation F: Add paramedicine to the Financial Sustainability Program

That the Department's Financial Sustainability Program formally evaluate paramedic-led substitution and secondary-triage models as an efficiency lever, alongside its existing strategies of reducing locum and agency usage and reforming rostering, on the basis that the evidence in Section 4 shows this can lower total system cost without reducing frontline capacity.

Recommendation G: Include paramedicine in any independent, whole-of-system review

That any independent, whole-of-system review of the Tasmanian health system, as separately sought by AMA Tasmania and Sphere MAC in their submissions to this Inquiry and previously by the author, include an explicit term of reference examining paramedicine's role in demand management, prevention and primary care substitution.

Recommendation H: Support Commonwealth reform

That the Committee's report record its support for the establishment of a Commonwealth Chief Paramedic Officer and for Medicare Benefits Schedule recognition of paramedic-led care; consistent with the author's supplementary submission to the Senate Rural and Regional Affairs and Transport References Committee of 5 August 2026, the Australasian College of Paramedicine's and the Australian Council of Ambulance Unions' national Position Statements; on the basis that matching Commonwealth recognition would materially assist Tasmania's own efficiency task by better mobilising the profession and unlocking co-funded and other models of care.

Appendix A: Abbreviations

ACAU	Australasian Council of Ambulance Unions
AMA	Australian Medical Association
ARRS	Additional Roles Reimbursement Scheme (UK NHS)
COPD	Chronic Obstructive Pulmonary Disease
CPO	Chief Paramedic Officer
ED	Emergency Department
FTE	Full-Time Equivalent
GAA/FPH	Government Administration A – Financial and Operational Performance of Health
GP	General Practitioner/General Practice (context governs)
KPI	Key Performance Indicator
MBS	Medicare Benefits Schedule
NHRA	National Health Reform Agreement
NHS	National Health Service (UK)
RACGP	Royal Australian College of General Practitioners
SIOC	Statewide Integrated Operations Centre
Sphere MAC	Sphere Management Advisers + Consultants

Appendix B: A Chief Paramedic Officer for Tasmania

This draft is offered as a starting point for Committee consideration. The detailed position description would benefit from consultation with Ambulance Tasmania, the Department of Health, current and past Chief Paramedic Officers in Victoria and the Northern Territory, the paramedicine profession and the Paramedicine Board of Australia before adoption in a final form.

Issue

Tasmania currently does not have a Chief Paramedic Officer or an equivalent nominated senior clinical lead for paramedicine, despite paramedics sitting at the centre of the Department of Health's operational Key Performance Indicator and despite the State's older, more dispersed and more chronically unwell population than the national average.

Position

Tasmania should establish a Chief Paramedic Officer (CPO) within the Department of Health, reporting at a level equivalent to the Chief Medical Officer, Chief Nursing and Midwifery Officer and Chief Allied Health Officer, with a standing seat on the Statewide Clinical System Governance Committee and Health Senate.

Proposed functions

- Professional, clinical and ethical leadership for paramedic practice across Ambulance Tasmania and the wider health system.
- Design, commissioning and clinical governance of community paramedicine, secondary-triage and hospital-avoidance programs, including the pilot proposed at Recommendation B of this submission.
- Workforce planning that accounts for registered paramedics working outside Ambulance Tasmania, in aged care, industry, primary care and community roles.
- Accountable liaison between Ambulance Tasmania and the Statewide Integrated Operations Centre for real-time patient flow data.
- Advice to the Minister and the Secretary on paramedicine's contribution to prevention, primary care access and demand management, including under the 20-Year Preventive Health Strategy.

Precedents

Victoria has maintained senior paramedicine clinical leadership with a Chief Paramedic Officer since 2017 following discussions begun by the author in 2015. The Northern Territory established a CPO role in 2024 following a government-ordered review of clinical governance in its ambulance service, and appointed its first officer in early 2025. South Australia has also committed to establishing a CPO. The Australasian College of Paramedicine's national Position Statement on Chief Paramedic Officers supports the establishment of the role across all Australian jurisdictions, as does the Australasian Council of Ambulance Unions.

Policy Alignment

Australasian College of Paramedicine, Position Statement: Chief Paramedic Officers (<https://paramedics.org/storage/news/Chief-Paramedic-Officers-Position-Statement-AUS.pdf>); NT Health, Office of the Chief Paramedic (<https://health.nt.gov.au/professionals/paramedicine>); and Recommendation A of this submission.