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| Non-Emergency Patient Transport Regulations 2015Regulatory Impact Statement |
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# Summary

Non-emergency patient transport (NEPT) is regulated in Victoria under the Non-Emergency Patient Transport Act 2003 (the Act) and the Non-Emergency Patient Transport Regulations 2005 (the 2005 Regulations).

This regulatory framework mandates requirements to establish a licencing system for private NEPT operators, and prescribes standards and requirements for the provision of NEPT including patient acuity, staffing of vehicles, qualifications of staff, stand-by accreditation, vehicles and equipment, and infection control.

The current regulations are due to expire on 8 November 2016, having been extended for a further 12 months from their former expiry date of 8 November 2015.

In accordance with the requirements of the Subordinate Legislation Act 1994 and the Victorian Guide to Regulation, this regulatory impact statement (RIS) is required to assess the proposed Regulations in terms of their objectives and their effects, alternative approaches to achieving those objectives, and an assessment of the costs and benefits of the regulations and the alternatives.

## Objectives

The primary objective of the proposed Regulations is to provide for the safety and quality of care of patients receiving treatment and transport from NEPT operators. The proposed Regulations set minimum requirements, with the aim of minimising the risk of harm to patients, while not imposing onerous or unjustified costs on those being regulated.

The secondary objective of the proposed Regulations is to prescribe fees, forms and other matters required to be prescribed under the Act in relation to NEPT operators. This provides the mechanisms by which NEPT operators can meet their requirements under the current Act.

A further objective that is not articulated in the proposed Regulations to is provide for improved efficiency and flexibility of licenced NEPT fleets and to improve the efficiency of Ambulance Victoria by reducing the use of the AV emergency vehicle fleet for NEPT transports.

There are specific objectives in relation to certain parts of the proposed Regulations detailed in table I below.

Table I: Objective of regulation

|  |  |
| --- | --- |
| Area of regulation | Objective |
| Categorising patient acuity and specifying minimum requirements for staffing of NEPT vehicles | To ensure that the standard of treatment and monitoring of patients before and during transport is safe, clinically appropriate and timely. |
| Specifying requirements for staffing and competence and qualifications of staff | To ensure that the vehicles are crewed with sufficient staff who are skilled, competent and qualified to manage the clinical needs of the patient being transported. |
| Specifying fees for applications | To facilitate efficient administration of the Act by ensuring fees received are appropriate to the cost of Regulation activities. |
| Requiring that licencees must have their quality assurance plan accredited and specifying minimum elements that must be included in the Plan | To ensure that all licencees are operating to an accredited quality assurance plan which contains prescribed elements considered necessary to manage patient safety during transport |

### Nature and extent of the problem being addressed

Non-emergency patient transport exists to transport patients who require clinical monitoring, but who do not require time critical emergency transport, to and from hospitals, aged and disability care facilities, and home.

The NEPT service is allocated to the patient by either the Emergency Services Telecommunications Authority (ESTA), Ambulance Victoria (AV) or the sending hospital. Patients cannot choose the service provider. NEPT offers a range of transport platforms to meet the various clinical needs of patients ranging from low acuity to high acuity. These transports may be planned or unplanned. It is necessary to ensure that right transport platform is provided to meet the clinical needs of the patient being transported.

More than half of the NEPT services in Victoria are provided by twenty licenced private businesses. The remainder is provided by AV. Six of the licenced private businesses also currently provide NEPT services under contract to AV.

The Government acknowledges that:

* patients are more vulnerable when requiring treatment and transport, and hence their interests need to be protected
* safety-related incidents or issues that produce adverse patient outcomes do occur
* there are benefits to the community as a whole in ensuring high quality health care
* there are market failures that warrant intervention.

Common types of ‘market failure’, where there is a case for the government to intervene, relevant to the private non-emergency patient transport sector include:

* Addressing information and power asymmetries in the health care system:
	+ - Patients cannot choose the transport provider for non-emergency patient transport (NEPT). Most patients do not have the knowledge to determine which transport platform would best suit their needs. Some patients are not well enough to be aware of their transport arrangements.
		- The choice is made for them by ESTA, AV, hospitals, or their medical practitioner.
		- Unless otherwise advised many patients would not be aware they were being transported by a private business.
* Addressing public health and safety:
	+ - There is an expectation in the community that the government has a role in ensuring minimum standards of safety and quality in health care for patient transport. Not all private NEPT businesses would be subject to oversight in the absence of Regulations as it is only a minority of private NEPT providers that are contracted to AV.
			* Without adequate oversight (and sanctions) there is a risk that some NEPT services would not meet the necessary standards to ensure the safety and quality of care of patients during transport. There is a risk that some NEPT services may not employ suitably qualified staff, may not equip vehicles suitably, or may not allocate appropriate staff and vehicles with the necessary skills, competence and equipment to manage the clinical needs of the patients. The consequences of a failure to meet the clinical need of patients may be a worse patient outcome than would otherwise have occurred, or death.

The Government has an interest in high quality, efficient patient transport services to complement the Ambulance Victoria service and to ensure emergency vehicles are available for their primary function. Without it, we would see increased demands continuing to be placed on Ambulance Victoria leading to increased funding requirements and further deterioration in emergency response times.

Quantifying the extent of a ‘quality problem’ in patient transport is difficult, both due to differing definitions and perceptions of what may constitute ‘quality’ as well as a lack of quality performance data for NEPT services. Quality in health systems is defined by the World Health Organisation[[1]](#footnote-1) as:

* “effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
* efficient, delivering health care in a manner which maximizes resource use and avoids waste;
* accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
* acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
* equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
* safe, delivering health care which minimizes risks and harm to service users.”

Government intervention is intended to reduce the risks associated with NEPT and the number of negative consequences with social and economic costs that may arise, affecting individuals, the community and the sector, including:

* loss of life
* decreased quality of life
* longer-term or additional treatment
* longer-term care and rehabilitation
* financial impact on patients, family and carers
* cost of investigations and inquiries
* cost of legal action and negligence claims.

The data provided in this RIS supports a role for government intervention in the NEPT sector, to ensure minimum standards of patient safety and quality are met.

### Summary of costs and benefits of the proposed measures compared to the base case

The estimated costs and benefits of the proposed Regulations are indicated in the following table. They reflect costs and benefits that are additional to a hypothetical base case of no regulation. That is, they represent the cost or benefit of imposing the proposed Regulations on the private non-emergency patient transport sector as if there were no current regulations. However, for NEPT businesses, where regulations have been in place for the past 10 years, any costs of the proposed Regulations would largely be incremental.

Table II: Costs

| Area of Regulation | Total costs per year $ | Discounted 10- year cost $ |
| --- | --- | --- |
| Specifying fees for applications | 40,081  | 469,879  |
| Assessment of patient acuity | 0 | 0 |
| Staffing requirements  | 3,917,837 | 45,008,010 |
| Accreditation requirements | 69,974 | 805,645 |
| **TOTAL** | **4,028,612**  | **46,283,534**  |

In total, these Regulations result in a 10 year incremental cost of $46,283,534

Table III: Benefits

|  |  |  |
| --- | --- | --- |
| Area of Regulation | Total benefit per year $ | Discounted 10- year benefit $ |
| Specifying fees for applications | 0 | 0 |
| Assessment of patient acuity | 3,643,400 | 41,948,270 |
| Staffing requirements  | 0  | 0  |
| Accreditation requirements | 0 | 0 |
| **TOTAL** | **3,643,400**  | **41,948,270**  |

In total, these regulations result in a 10 year incremental benefit of $41,948,270.

**The net 10 year incremental cost of the Regulations (incorporating direct and indirect costs) is: $41,948,270 - $46,283,534 = $4,335,264.** This cost is considered reasonable over the life of the Regulations given the Regulations have been developed primarily to protect patient safety and will govern at least 3.5 million patient transports in that time.

It should also be noted that adoption of the proposed Regulations will remove a further $573 million in costs imposed on the community by the 2005 Regulations (see section 5).

One approach to judging the net benefits of the proposed Regulations is to use a ‘break-even’ analysis. This involves placing a value on certain undesirable outcomes, and determining how many of these undesirable outcomes would need to be avoided due to the Regulations in order to justify the costs of the Regulations. The undesirable outcomes in relation to patients being transported are adverse events leading to loss of life, decreased quality of life or longer-term or additional treatment. As noted previously, these are very difficult to quantify.

The majority of costs incurred (excluding benefits) are attributable to measures aimed at ensuring minimum levels of safety and ensuring quality care (that is, suitable mode of transport, appropriate staffing, quality assurance, etc.).

Data provided by Ambulance Victoria shows 184,000 NEPT transports per year (not including clinic cars) were undertaken by AV directly or by its contractors. AV advise that there are approximately 400 adverse events during AV NEPT transports per annum. It is not possible to determine if the Regulations will result in any reduction of current NEPT adverse events. However for some calculations it has been assumed the Regulations would be responsible for some reduction in adverse events compared to the base case although not in relation to AV allocated transports which are assumed to be unchanged.

There are occasional media reports of deaths when an emergency ambulance did not arrive in time to treat and transport the patient. As these regulations will result in improved emergency ambulance response times due to removing impediments to ESTA and AV in allocating NEPT transports, arguably some of these deaths may be avoided in future.

The Department of Health and Human Services (the department) has made an assumption the number of deaths prevented and consequent extension of life per annum to be 2 patients achieving an additional 10 years of life each. The value of a statistical life year in Australia is now $182,170.[[2]](#footnote-2)

Using these figures, it is possible to conduct a break-even analysis.

Assuming 2 deaths per year will be prevented by the Regulations, and this results in an extra 10 years of life for each patient then the savings attributable to the regulations are 2 (patients) x 10 (years) x $182,170 (value of a statistical life year) = $3,643,400. Therefore, the breakeven point for the Regulations $3.6 million.

The department considers this a probable underestimate of the outcome of the proposed Regulations as it is likely that more than 2 deaths would be prevented.

The break-even analysis does not include prevention of adverse events due to delays in patient transfers, either NEPT or emergency. There is no data available on which to base a costing of prevented adverse events. However, this RIS relied on a multi-criteria analysis (MCA) as the decision rule in assessing cost-benefit analysis of the components of regulation, recognising that such break-even analysis is very sensitive to assumptions and it is difficult to directly attribute causes and effects in most cases. The MCA analysis therefore focuses on whether or not the proposed Regulations provide for the safety and appropriate clinical care to be provided to patients.

The MCA scores for each of the options considered in the RIS are noted in the tables below.

Table IV Fee options

|  |  |
| --- | --- |
| Options for fees | MCA score |
| **Option A**: Variable fees at full cost recoveryThe proposed Regulations set licence fees on the basis of a combination of a fixed administrative component that applies to all licencees irrespective of size, and a variable component determined by vehicle numbers that allocates a further component of the licence fee according to the estimated time required to undertake regulatory activities. It is assumed that the larger the fleet the larger time for the regulatory oversight required. | +5.61 |
| **Option B**: Variable fees at partial cost recovery.The same principles for apportioning fees as option 1 but only set at 50% of cost to the Department  | +3.96 |
| **Option C**: Flat fees at full cost recovery.Applying a flat fee for initial licencing and renewal of licences regardless of the size for the business.  | +4.95 |

Table V Patient Acuity Options

| Options for assessment of patient acuity | MCA score |
| --- | --- |
| **Option A:** Broader patient acuity assessment – the proposed regulations The assessment of patient acuity may be undertaken by a medical practitioner, a division one registered nurse, and a clinician employed by ESTA and AV. | +4.25  |
| **Option B**: Medical Practitioner only patient acuity assessment – the alternative regulatory approachThe assessment of medium and high acuity patients must be by a medical practitioner. Option B is a continuation of the current regulated requirement.  | -2 |

Table VI Staffing Options

| Options for Staffing (Vehicle Crewing) | MCA score |
| --- | --- |
| **Option A:** the proposed RegulationsThe licence holder must ensure that each NEPT vehicle is crewed by staff with suitable skills, knowledge/competence and qualifications to ensure each patient’s medical needs can be met for the duration of the transport.For medium and high acuity patients a suitably competent and qualified crew member must travel in the patient compartment with the patient at all times. | +3.5  |
| **Option B**: the current RegulationsThe licencee must ensure that each NEPT crew member has a prescribed qualification and is professionally competent through education or experience to provide patient care for the duration of the patient transport.The licencee must ensure that the crewing of the NEPT vehicle is in accordance with the prescribed requirements. | +2.5  |
| **Option C**: a Voluntary Code of PracticeAn industry developed Code of Practice for NEPT licencees to adopt voluntarily | 0  |

Table VII Quality assurance plan options

|  |  |
| --- | --- |
| Options for Quality Assurance Plan Accreditation | MCA score |
| **Option A** Prescribed minimum requirements in the accredited quality assurance plan | +4 |
| **Option B**No prescribed minimum requirements in the accredited quality assurance plan | +1.5 |

### Why other approaches are not appropriate

The proposed Regulations were assessed against identified feasible alternatives in each of the main areas. In each case, the proposed Regulations were considered to be superior, because they received a higher overall score when assessed against an MCA, which assists comparing options where costs and benefits are not able to be fully calculated.

Voluntary approaches such as Codes of Practice were considered but were assessed to be effectively the same as the base case.

### Consultation

A primary function of the regulatory impact statement (RIS) process is to allow members of the public to comment on the proposed Regulations before they are finalised. Public input provides valuable information and perspectives and improves the overall quality of regulations. Accordingly, feedback on the proposed Regulations is welcomed and encouraged.

All interested parties are invited to provide comment on this RIS. Parties may wish to respond to any part of this RIS or the draft Regulations, although particular comment is invited on: whether there are any specific unforeseen impacts of the proposed Regulations; and if the assumptions used in calculating costs and benefits of the proposed Regulations are reasonable.

Initial consultation was undertaken with NEPT licencees, Ambulance Victoria, Adult Retrieval Victoria, United Voice Ambulance Section (the Ambulance Employee’s Union), hospitals and the Australian Day Hospitals Association to inform the drafting of the Regulations.

### Rationale for government intervention

The second reading speech for the Act stated “Non-emergency patient transport services primarily involve work such as transporting patients between hospitals and from hospital to home. Patients transported by private providers are often frail requiring transport via stretcher.”

The objective of the proposed Regulations is to provide for the safety and quality of care of patients being transported by NEPT providers. In considering the rationale for the proposed Regulations:

* To what extent is it the role of government to address residual safety risks, given the high level of voluntary compliance with the existing Regulations?
* In the absence of the Regulations, would other incentives be sufficient to minimise the incidence of adverse events and achieve appropriate safety outcomes? To what extent do Regulations contribute to safety outcomes?

### Base case

Based on long standing interaction with the sector, it is the department’s view that there is a high degree of compliance with requirements in the Regulations; however, the Regulations are required to ensure and enforce compliance. In this regard:

* In the absence of the Regulations, is the assumed level of compliance referred to in the RIS reasonable? To what extent would NEPT operators comply with the proposed requirements as part of standard business practice?

In assessing the base case it is noted that not prescribing forms and fees as required by the Act would prevent private NEPT operators for continuing in business. If no fees or application forms were prescribed no private NEPT provider would be able to apply for a licence or a renewal of a licence. The Act provides that it is an offence to operate a private NEPT service without a licence. Therefore the outcome of no regulations would be that the private NEPT sector could not continue to operate. However this is an impractical approach to take to assessing the base case and calculating the MCA. In order for the MCA assessment to be relevant it has been assumed that all private NEPT operators are licenced.

The base cases for the remaining components therefore have been assessed on the basis of no specific regulation existing for that element only.

### Licence Fees

The proposed licence fees are based on the cost of the elements necessary for the Department to carry out in order to issue licences. Are the calculations used to determine the licence fees considered reasonable. If not in what respect do they require correction? Are any assumptions underpinning the calculations incorrect?

### Assessment of Patient Acuity

The proposed Regulations aim to ensure that a suitably qualified person assesses the acuity of patients in order to assign the appropriate transport for the journey. Does this provide sufficient clarity to proprietors about who and what should be assessed?

The proposed Regulations will allow Division one nurses and paramedics employed by AV, and Division one nurses from a facility where a patient departs, to assess the patient acuity. Are there any risks to patients created by this change and if so, are they significant?

Have all relevant costs and benefits have been considered?

### Staffing

The proposed Regulations place requirements on proprietors regarding the sufficient number of appropriately educated and competent staff to crew the vehicles. Does this provide sufficient clarity to proprietors?

Are there circumstances where the Regulations do not offer sufficient flexibility to proprietors? If so, what is the additional cost of this? Are there alternative staffing options, either in regard to staff numbers or skill mix, which should be explored?

The RIS describes three options for requirements for NEPT vehicle staffing within this analysis. Have all relevant costs, benefits and implementation issues been considered? Are the assumptions made in calculating the incremental costs of these requirements reasonable?

In considering requirements in relation to staffing, do you have any comments on the cost-effectiveness of staffing requirements compared to other safety measures?

### Other

The proposed Regulations aim to clarify what proprietors are expected to do to meet the requirements under the Act. Do the proposed Regulations give sufficient clarity to proprietors? If not, in relation to which part of the Regulations would greater clarity be useful?

Some Regulations were not analysed in this RIS because they are considered ‘business as usual’ for the sector (see Section 8). Is this a reasonable assumption? Are there further incremental costs attributable to these Regulations which are not addressed?

Do the proposed Regulations have any impacts on competition not identified in this RIS?

Overall, are there any practical difficulties in meeting any of the requirements set out in the Regulations?

Overall, are there any transitional or implementation issues associated with the proposed Regulations?

**Responses are to be received by the Department no later than 5pm Sunday 1 November 2015.**

# 1 Introduction

## 1.1 The non-emergency patient transport sector

Specific regulation of the NEPT sector in Victoria commenced in 2003 to meet a community need and to ensure the more efficient use of emergency ambulance services. The sector had previously been regulated by the Taxi Directorate.

The 2013 ACIL Allens review of the NEPT sector described the sector as follows: “The NEPT sector in Victoria was established in 1993 with the separation of the emergency and non-emergency transport services of Victoria’s ambulance services. Originally, private providers of NEPT services had to comply with the Transport Act 1983 and be licensed by the Taxi Directorate. The Non-Emergency Patient Transport Act 2003 (the NEPT Act) recognised the industry’s unique characteristics and established a regulatory framework for NEPT.

NEPT is defined by the NEPT Act as transport of persons to, or from medical services:

* By road:
	+ - ‘using a stretcher carrying vehicle; or
		- ‘where the persons being transported are provided with specialist clinical care or monitoring

 while being so transported.’

* By air:
	+ - ‘where the persons being transported are transported on stretchers; and
		- are provided with specialist clinical care or monitoring by the person operating the transport service’.

This definition establishes that NEPT road services include those using a stretcher-carrying vehicle and those in a non-stretcher carrying vehicle, where specialist clinical care or monitoring is provided. NEPT air services on the other hand, cover only instances where both the patient is in a stretcher, and the patient is provided with specialist clinical care or monitoring.

The size of the current NEPT sector is not well understood. Indicative modelling ….. estimates the Victorian road NEPT market is worth $152 million (all figures are based on 2011–2012 data).”[[3]](#footnote-3)

There are currently 20 licenced NEPT operators who are licenced to operate 339 vehicles and 5 aircraft. Despite a number of requests about half of the licenced private NEPT providers did not provide data on their operations to assist with this RIS. As a result it has been necessary to estimate the size of the sector, and how many people are employed.

Of the licenced 20 operators, six are currently contracted to AV and supply approximately 55% of the AV NEPT services. Licenced NEPT operators undertake approximately 200,000 non-emergency patient transports independently and a further 150,000 transports annually for Ambulance Victoria. It is estimated that there are about 1000-1200 equivalent full time positions in the sector.

Victoria is unique within Australia in having a significant, growing, and competitive non-emergency patient transport sector. Victoria is also the only State or Territory that has a specific Non-Emergency Patient Transport Act to regulate the NEPT sector.

Victorian NEPT operators are regulated under the Non-Emergency Patient Transport Act 2003 (the Act). Under the Act private NEPT operators are required to be licenced by the Department before they can provide NEPT services. AV, and public and denominational hospitals are not required to be licenced to provide NEPT services, however the remainder of the regulations apply to these NEPT services.

According to page 1 of the RIS prepared for the introduction of the first NEPT regulations in 2005, the regulation of the NEPT sector and the associated licencing requirements were originally introduced in 2005 to provide assurance to users of the service that minimum standards were in place.

In considering whether or not to licence a NEPT operator, the Secretary of the Department of Health and Human Services (DHHS) is required by the Act to take a number of factors into account. These include:

* whether the proprietor is a fit and proper person to carry on the service,
* the suitability of the equipment and vehicles to be used,
* whether the proposed operating arrangements for the management and staffing are suitable and comply with the regulations,
* whether there are arrangements for maintaining the quality of the service are appropriate, and
* whether there are arrangements for evaluating, monitoring and improving the quality of the service.[[4]](#footnote-4)

Proposed licencees may also be approved in principle prior to purchase of vehicles, in which case licencing is subsequently granted on terms that are consistent with the approval in principle.

The Act is supported by the Non-Emergency Patient Transport Regulations 2005 (the 2005 Regulations), which are intended to provide for the safety and quality of care of patients being treated or transported by NEPT operators.

The 2005 Regulations:

* set minimum standards of requirements relating to staffing, staff qualifications, suitability of equipment and vehicles and equipment, and infection control.
* specify consumer protection arrangements, including consumer information and complaints resolution requirements.
* detail a range of requirements to support the secretary’s regulatory functions in the Act, such as licencing, application forms, licence fees and annual fees.

The Act and Regulations, while imposing minimum standards for the sector, are not considered to impose a significant barrier to entry to the market. Licence fees are minimal, in comparison to non-legislated businesses costs, and accreditation costs are in line with costs across all industries that are accredited by third parties. In many cases accreditation costs are a cost of doing business and are not an additional cost imposed by regulation. Costs associated with purchasing and fitting out vehicles, and employing suitable staff would apply whether or not regulations existed. As the regulations impose minimum standards for both these elements additional costs are imposed on the participants of the sector that would otherwise operate in a substandard manner and that would otherwise be required to meet the minimum standards imposed by regulation. To that extent these costs have been included in the RIS.

## 1.2 The non-emergency patient transport sector

There are a range of participants in the NEPT sector including the Victorian Government as regulator and part-funder, service providers, purchasers and requestors of services, and end-users. There is a complex series of interrelationships between market participants. Ambulance Victoria (AV) has multiple roles as a transport provider, purchaser, and for some services, a booking and dispatch role.

AV has the monopoly role for the provision of Community Service Obligations (CSOs). These services are provided free to pensioners and health care card holders. In metropolitan areas, AV contracts out its CSO road services, while in regional areas, AV contracts out some of its services and meets others through its internal resources. Health services may have their own fleets, contractual arrangements or use AV.

Call taking and dispatching arrangements are currently organised in two major ways: (i) centrally through the Emergency Services Telecommunications Authority (ESTA) – with NEPT services dispatched after either: (a) ‘000’ calls triaged through RefCom; or (b) through the ‘1300’ number for planned services known in advance – with AV’s CSO market organised through this arrangement; and (ii) through devolved arrangements, involving private providers, which have their own call-taking and dispatching arrangements, used to service the inter-hospital transfer market.[[5]](#footnote-5)

## 1.3 How the NEPT system operates

There are 3 ways a NEPT vehicle transport can be organised.

The first method is the triple zero ESTA call dispatch where ESTA personnel triage the triple zero calls and allocate a vehicle according to the assessed needs of the patient. The second method is the booked NEPT service which is booked through AV direct. This service can be booked by medical facilities and medical practitioners only and may not be booked by the patient directly. In both these cases, as explained earlier, if the patient acuity is not assessed by a medical practitioner and is of medium or high acuity, an emergency vehicle must be dispatched. The flowchart below explains the current call taking and allocation process. NEPT may be allocated through either the grey or the blue boxes.

#### Ambulance Victoria Call Response options

**Triple zero triage process**

**Scheduled non-emergency patient transport**

Alternative Response

Via RefCOM

Emergency

(road and air)

Non-emergency

(road and air)

**Metropolitan areas**

AV operated clinic cars.

Private providers contracted for stretcher road services.

**Rural areas**

Mixture of contracted private providers and AV resources.

Secondary triage service for low acuity callers.

Staffed by AV paramedics and nurses.

Provides phone advice.

May lead to dispatch of non-emergency patient transport, locums, mental health, etc.

May also be returned for emergency ambulance response.

Ambulance crews.

Single MICA units.

Ambulance Community Officers.

Community emergency response teams.

Trained fire fighter first responders.

Remote area nurses.

The third method of organising NEPT transport is for a hospital to book an NEPT vehicle directly though a contract with a private licenced NEPT provider.

## 1.4 Purpose of this regulatory impact statement

The 2005 Regulations are due to sunset on 8 November 2016.

In accordance with the requirements of the Subordinate Legislation Act 1994 and the Victorian Guide to Regulation, an RIS is required to assess the proposed Regulations in terms of their objectives and their effects, alternative approaches to achieving those objectives, and an assessment of the costs and benefits of the regulations and the alternatives. An assessment should also be undertaken of the implications of the proposed Regulations on competition.

In assessing the most effective option to achieve the identified objectives, the RIS must determine decision criteria to assess each option. These criteria must relate directly to the objectives of the proposed Regulations and the Act.

By virtue of the framing of the Act, the 2005 Regulations and the proposed Regulations respond specifically to particular provisions of the Act rather than being self-contained. Therefore, the assessment of the costs and benefits of the proposed Regulations is only on the ‘incremental’ costs and benefits arising from the proposed Regulations and not the impacts that are attributable to the provisions of the Act.

A copy of the draft Regulations is at Appendix C.

# 2 The reasons for regulation

## 2.1 Background

Private NEPT services are integral to the transport of patients in the Victorian health system.

The Victorian Government provides funding for non-emergency patient transport services through:

* Funding to Ambulance Victoria to provide free transports to pension and health care card holders (Community Service Obligations).
* Funding of health services that is incorporated into activity price for the purchasing of non-emergency transport for hospital patients where the hospital is responsible for payment (primarily inter-hospital transports).

No funding is provided to the private hospital sector.

Non-emergency patient transports are also funded through a small number of private health insurance policies, Ambulance Victoria membership fees, third-party patient fees from WorkSafe, Transport Accident Commission and Department of Veterans Affairs, and from full-fee paying patients.

The private NEPT sector provides approximately 350,000 patient transports per annum including the AV contracted transports.

## 2.2 Ambulance Victoria’s NEPT activity

Ambulance Victoria’s role in the NEPT market includes:

* Responsibility for providing Community Service Obligation and membership patients transports
* Having additional capacity available to manage increased demand during emergency events.
* Covering rural and regional areas where there is not enough demand for a commercial NEPT service to operate.

Over the past five years, Ambulance Victoria provided the following non–emergency patient transports:

**Table 2.1 NEPT transports**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Transport type | 2009-10 | 2010-11 | 2011-12 | 2012-13 |
| Metropolitan road: stretcher | 137,259 | 143,176 | 143,552 | 143,206 |
| Rural road  | 53,101 | 53,098 | 55,035 | 34,028 |
| Fixed-wing transports | 3,491 | 2,733 | 2,663 | 3,082 |
| **TOTAL** | **193,851** | **199,007** | **201, 250** | **180,316** |

In metropolitan Melbourne, Ambulance Victoria contracts out approximately 90 per cent of all road non-emergency patient transport to private providers licensed by the Department. Ambulance Victoria also has its own Clinic Transport Service which is operated by paramedics, providing seated transport in metropolitan areas.

In regional and rural areas, Ambulance Victoria contracts out the provision of some non-emergency patient transport services and meets remaining service demand through its internal resources.

Ambulance Victoria also provides non-emergency patient transport via fixed wing aircraft, with some over-flow work contracted to the Royal Flying Doctors Service. Hospitals may also contract directly with private aero NEPT providers.

In 2013-14 AV paid $40 million in contracting fees for NEPT transports to private NEPT operators.[[6]](#footnote-6)

From 1 July 2015 Ambulance Victoria fees for non-emergency patient transport are:

* $309 per transport - metropolitan areas
* $523 per transport - rural areas

## 2.3 Rationale for government intervention

Governments generally intervene in markets and regulate if there is a risk, actual or potential, to consumers.

The Allen ACIL review of Non-Emergency Patient Transport, commissioned by the Department of Health in 2012 examined the risks associated with NEPT. They commented:

“Possible risks: NEPT transportation

It is difficult to assess the degree of risk that stems from NEPT transportation based on available evidence. The Ambulance Victoria (AV) Health Sector Satisfaction Survey …outlines that satisfaction with non-emergency stretcher services was highest in relation to clinical care, caring/empathy and the professionalism of the workforce providing the service (AV 2013b). While this suggests a high level of satisfaction from health services using NEPT services, issues of non-compliance with the regulated standards may provide some further evidence. These data are not currently collected by the Department.

Another way to assess the risks to public safety is to examine whether any workforce ‘risks’ are evident, from the scope of activities completed. The AHMAC Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law (2009) identifies 13 risk-factors that can be used to evaluate whether a health profession possesses a risk to the public. These have been identified below, in Table 2.2 with an assessment provided about the risks that may result from a NEPT service.“[[7]](#footnote-7)

**Table 2.2 Risk factors professional activities posing a risk**

|  |  |
| --- | --- |
| Risk factor | Application in a NEPT environment |
| 1. Putting an instrument, hand or finger into a body cavity. involving placing an instrument into a body cavity.  | Yes. Patient observations may be required |
| 2. Manipulation of the spine.  | No. |
| 3. Application of a hazardous form of energy or radiation. | No. |
| 4. Procedures below the dermis, mucous membrane, in or below surface of cornea or teeth.  | No. |
| 5. Prescribing a scheduled drug, supplying a restricted drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs.  | Yes. A restricted drug may be supplied for Medium and High Acuity transports in accordance with s19 of the Drugs, Poisons and Controlled Substances Act 1981. |
| 6. Administering a scheduled drug or substance by injection.  | Yes. As per item 5. |
| 7. Supplying substances for ingestion.  | Yes. As per item 5. |
| 8. Managing labour or delivering a baby. | No. |
| 9. Undertaking psychological interventions to treat serious disorders with potential for harm. | No. |
| 10. Setting or casting a fracture of a bone or reducing dislocation of a joint. | No. |
| 11. Primary care practitioners who see patients with or without a referral from a registered practitioner. | No. |
| 12. Treatment commonly occurs without others present.  | Dependent on whether ‘specialist clinical care or monitoring’ as defined by the NEPT Act can be defined as treatment. Low acuity transfers may provide monitoring in the absence of others present.  |
| 13. Patients commonly required to disrobe. | No. |

In an environment where NEPT operators are licenced but no other Regulations exist there is a risk that some providers will pursue a competitive advantage that may result in decreased safety and quality. As outlined in Section 2 under ‘Nature and extent of the problem’ there is evidence that health care markets fail to operate efficiently when left to their own devices. This market failure is associated with the following:

Information asymmetries: health care consumers do not necessarily have sufficient information to make informed decisions about the type, quality and price of the service they will receive. In accessing NEPT the patient cannot chose their NEPT service provider. If the patient rings triple zero AV allocate a transport from one of their contracted private providers or provide the service using an emergency vehicle. The same process occurs for transports booked directly with AV. For transports organised by health services the service will either access the AV service or use their own contracted NEPT provider. In the latter case the hospital chooses who provides the transport. Further, patients are reliant on the providers of health care to advise what is required, and may not have the ability to ask questions or seek other options and opinions.

Consumers’ access to the market: the circumstances under which consumers seek patient transport is different from a normal market arrangement. Patients are not able to choose their NEPT provider. In the event of an emergency call, ESTA triages the call and has absolute discretion to allocate either an emergency ambulance or an NEPT provider contracted to AV. In the event of a booked transport either the treating health service, if they have a contract with a licenced NEPT operator, or AV, will allocate the transport to a NEPT operator.

Limited price signals: in a standard market situation a consumer can select a product, taking into consideration the price; however, the costs of AV provided NEPT services are fixed by the Government. The costs of NEPT services that are contracted directly by the health service are agreed between the health service and the NEPT operator. The patient has no capacity to negotiate the cost of the transport or choose a provider based on cost. Depending on the destination of the NEPT transport the costs may be recoverable by the patient if they have private health insurance or have taken out membership with AV.

A market-driven scenario would not enable government to meet its primary objective of ensuring minimum standards of safety and quality of health care for Victorians.

## 2.4 Nature and extent of the problem

The Ambulance Services Act 1986 contains a range of mechanisms by which the government and the department can oversee, monitor and set standards in the emergency ambulance services to ensure patients receive high quality care. These powers do not currently extend to directly regulating the standard of care provided by private providers in the non-emergency sector.

In metropolitan Melbourne, private businesses undertake the majority of non-emergency transports through either direct arrangement with purchasers, such as hospitals or through contractual arrangements with AV. Outside metropolitan Melbourne, both AV and private providers provide non-emergency transports. Currently six private NEPT businesses are contracted to AV.

AV is also the provider of last resort and will provide the transports using emergency vehicles where there is no market for private providers. This will typically be remote rural areas. Given the broad range of patients currently transported by private providers of non-emergency transport services, the term ‘non-emergency’ should not be taken to mean ‘not seriously ill’ nor to mean ‘no clinical skills are required’ to transport these patients. Rather, patients transported by the NEPT sector are those who do not require and are not likely to require a time critical ambulance response. The users of NEPT services are patients with clinical needs that require monitoring who are travelling from home to health services, between health services and from health services to home.

Approximately 350,000 patient transports are undertaken by private NEPT organisations annually. The Government considers it essential to ensure the quality of the services provided by these organisations.

Patients, as a result of age, illness and frailty, rely on health services and health professionals to make decisions regarding patient transport service providers on their behalf. Patients do not have the ability to elect to travel with a NEPT provider other than that organised by the AV, the health service, or the health practitioner. Patients do not have the necessary knowledge to discern whether an appropriate level of clinical care is being provided by a NEPT organisation.

If there were no Regulations in place the NEPT sector could not function. Section 5 of the Act creates an offence to provide a private NEPT service without a licence. However Section 14 of the Act requires any application for a licence to be in the prescribed form and accompanied by the prescribed fee. Both the forms and the fees are prescribed by the Regulations so without regulations there is no capacity for a NEPT operator to apply for a licence.

Without the private NEPT services the provision of all NEPT in Victoria would revert to AV. AV are not resourced to undertake the entire NEPT service for Victoria. As a result NEPT transport services would expected to be substantially reduced and would be far less timely and reliable than currently. Hospitals would face greater difficulties in discharging patients and turning over beds which would lead to greater delays for those patients requiring admission through the emergency departments. Some patients requiring clinical transport may not be able to access the service due to demand constraints. As Ambulance Victoria would be required to transport all non-emergency patients there would also be a detrimental impact on their emergency service capability. It is likely significant job losses though the cessation of the private NEPT sector would also result.

As explained in Chapter 4, for the purposes of analysing the base case for this RIS we have assumed that NEPT providers are licenced but that no other Regulations apply. Otherwise the RIS would be meaningless as the base case would be no private NEPT providers.

The absence of Regulations would also mean that no minimum standards of patient care, staff qualifications and competence and vehicle and equipment requirements for the industry would exist. Potentially this could lead to a reduction in overall standards of patient care and outcomes.

The likely outcome of such an environment would be a worsening of patient outcomes within the NEPT sector. For example, in situations where a patient had an unexpected and sudden deterioration in their clinical condition and the NEPT crews were not competent to manage the patient, unnecessary deaths or suboptimal patient outcomes could be expected.

# 3. Identification of options

## 3.1 Objective

The prime objective of these regulations is to provide for the safety and quality of care of patients being treated and transported by NEPT services. The RIS for the 2005 Regulations articulated that the Regulations were developed to set down minimum requirements with the aim of minimising the risk of harm to patients – however this was not explicit in the objectives of the Regulations themselves.

The secondary objective of the regulations is to prescribe fees, forms and other matters required to be prescribed under the Act in relation to health service establishments. This provides the mechanisms to enable licencing and by which private NEPT operators meet their requirements under the current Act.

A further objective, which is not articulated in the Regulations, is to remove impediments to the allocation of vehicles that are appropriate to the clinical needs of the patient and thereby reduce the demand on emergency ambulances.

## 3.2 Base case

The ‘base case’ scenario is one where no Regulations exist. The Victorian Guide to Regulation requires the base case to be defined for the purposes of comparison (that is, what are the potential costs and benefits compared to the situation where the proposed approach is not adopted).

As stated earlier, it is an offence under the Act to operate a private NEPT service without a licence the effect of no regulations would be to force all private NEPT operators to close or breach the Act. In such a scenario AV would be required to meet any shortfall in NEPT service provision in their role as the provider of last resort with a significant cost impact for the Government.

However assessing the proposed Regulations against such a scenario is not helpful as it does not allow for a meaningful comparison. Therefore, for the purposes of assessing the base case for most elements of the proposed Regulations we have assumed NEPT operators are licenced but that no other Regulations exist.

While the removal of regulations for private NEPT operators would result in resource savings to government and NEPT operators associated with applying and assessing registration, inspecting and monitoring, this is not a relevant consideration while the Act is in operation.

In the absence of Regulations, there would still be drivers for NEPT operators to provide for patient safety and quality. These include the need to uphold business reputation as a business that did not provide appropriate care to patients during transport would soon lose contracts with hospitals and AV. While these drivers promote safety and quality, under the base case there is no power for government to act or intervene in circumstances where it is found that adequate patient safety and quality standards are not being met.

## 3.3 Options to achieve the objectives

In considering options it is noted that:

The Subordinate Legislation Act 1994 Guidelines (the guidelines) state:

“In most cases, when a responsible Minister is considering making a statutory rule or legislative instrument, the authorising Act or statutory rule will dictate what kind of instrument may be created. For example, where the authorising legislation provides for fees to be prescribed in statutory rules, there may be no discretion to set those fees by another method.”

The authorising Act in this case, the Non-Emergency Patient Transport Act 2003 sets down a regulatory framework requiring licencing of NEPT operators.

A number of provisions in the Act prescribe that forms, fees or registers will be prescribed in regulations.

In addition, Section 64 provides that the governor-in-council may make regulations to prescribe matters relating to: safety, cleanliness and hygiene; standards and requirements for the welfare of persons being transported, staffing; for vehicles and equipment; communication devices, and records.

In accordance with the Act and guidelines, remaking of the regulations for these provisions is the only viable option to give effect to the Act. Therefore, alternative regulatory options (for example, negative licensing instead of registration or guidance notes to proprietors in place of Regulations) are not considered in this RIS. Similarly, options involving information, such as league tables or benchmarking, while arguably addressing information asymmetries, are not viable, because this type of performance information is not available. As a result, options to be considered and assessed for the purposes of the RIS focus on those regulations that represent an incremental cost on the sector. These have been identified as:

* licence fees.
* Patient Acuity
* Staffing
* Quality accreditation

Licence fees must be prescribed in Regulations in order for an applicant meet the criteria set out in the Act to apply for a licence.

Defining patient acuity and who may assess it provides the basis for the NEPT licencee to determine the competencies of crews and the vehicle and equipment that are required to manage the medical needs of the patient during transport. In turn this impacts on the cost of doing business. These regulations also can have a significant impact on the demand for emergency ambulances as will be described later in the RIS.

Staffing is a large cost for NEPT operators. The competence of staff is a critical element in providing suitable care for patients and is therefore a significant risk. Regulations are required to ensure that care of patients is not compromised while not being unduly onerous of NEPT operators.

Quality accreditation is an element relied on by the department is assuring itself that all NEPT businesses are providing an acceptable level of patient safety and quality. To obtain that assurance the regulations need to set minimum standards for quality assurance. Doing so will allow the department to operate a risk based approach targeting areas of identified risk or poor performance rather than simply undertaking routine inspections that are not necessarily responsive to patient risk.

These aspects of the proposed Regulations are examined in chapters 4-7 where the nature and extent of the problems particular to those areas, as well as the arrangements in other jurisdictions, are discussed.

In addition, the Regulation’s objectives and options will be examined. The cost-benefit for each option will be assessed using multi-criteria analysis, resulting in a preferred approach.

The rationale for other regulations that are either of a low impact to the sector or where the cost is attributable to the Act and not the Regulations is set out in chapter 8.

## 3.4 Interstate Arrangements

Victoria is unique is having a contestable and substantial private NEPT sector. In turn Victoria is also unique in having a long standing Act and Regulations specific to NEPT which were considered to be necessary by the Government of the day as a significant amount of NEPT services was being delivered by arrangements outside the control of emergency ambulance services.

In NSW, NEPT is provided by the Ambulance Service of NSW (ASNSW), Local Health Districts (LHDs) and Specialty Health Networks (SHNs). LHDs and SHNs operate their own vehicle fleets and provide more than a third of NEPT services in NSW. Mandatory service specifications for NEPT services operating for the NSW Health department are set by NSW Health. This includes the crewing specification and crew qualification requirements. There is also one private air NEPT provider and one private road NEPT provider. The private providers are not currently required to be licenced. NSW has recently passed the Health Services Amendment (Ambulance Service) Bill 2015 that contains provision to allow for the regulation of the private NEPT sector. The Bill will not become active until supporting Regulations are made. NSW Health is currently undertaking discussions to determine if Regulations are required.

In Queensland the Queensland Ambulance Service (QAS) is the primary provider of NEPT in Queensland as part of their overall patient transport services. As NEPT is a QAS service the training and staffing arrangements are determined by QAS. There are two private NEPT operators and they are not required to be licenced. The governance arrangements to ensure patient safety and quality are self-regulated.

In South Australia the bulk of NEPT services is provided by the South Australian Ambulance Service (SAAS). SAAS prescribes training and staffing arrangements as part of the overall ambulance service. There are two private providers (one of whom is also licenced in Victoria) who are required to be licenced. A nominal licence fee of $150 applies. SAAS does not contract out any of its NEPT services.

In Western Australia, most NEPT are provided by St John Ambulance under contract with the Department of Health. There are at least 3 private NEPT providers servicing hospitals and the mines. One of the private NEPT providers is a large international ambulance service company. Licencing is not required. All services are managed by contracts. For the contract with St John’s Ambulance Service the Western Australian Government places its requirements in the contract and does not regulate the other private providers. The need for legislation will be considered in 2016[[8]](#footnote-8)

Ambulance Tasmania is responsible for most NEPT transports in Tasmania and sets the criteria for staffing and qualifications for its own services and the private services it contracts under the auspices of the Department of Health and Human Services and Tasmanian Health Service. Tasmania has passed a new Act to govern both emergency and non-emergency patient transport. Licencing of private NEPT providers is required. Supporting regulations are currently being developed.

# 4 Licence Fees

## 4.1 The nature and extent of the problem to be addressed

The NEPT Act requires every private NEPT operator to be licenced with the Department. The Regulations are required to prescribe the fees to be charged.

## 4.2 Objectives

To give effect to the Act by prescribing the fees as required by the Act.

The desired outcome is to facilitate efficient administration of the Act by ensuring fees are received appropriate to the cost of Regulation activities.

The objectives of prescribing fees are to:

* effectively recover the costs to the department of administrating the Act
* equitably distribute the costs incurred by government across the licenced NEPT operators.

## 4.3 Interstate arrangements

Table 4.1 shows the fees prescribed in other Australian states that apply to licencing of private NEPT operators.

#### Table 4.1 Arrangements in other Australian jurisdictions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Queensland $ | Western Australia $ | Tasmania $ | New South Wales $ | South Aust. $ |
| Approval-in-principle (AIP) | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| Variation or transfer of AIP | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| Registration | Not Applicable | Not Applicable | Required | Not Applicable | 150 fee |
| Registration renewal  | Not Applicable | Not Applicable | Required | Not Applicable | 150 fee |
| Variation of registration  | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| Stand-by accreditation  | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |

## 4.4 Identification of options

The Cost Recovery Guidelines[[9]](#footnote-9) set out 10 steps to consider when setting fees. These are set out in Appendix A, together with a summary of the department’s consideration of each step in accordance with the guidelines.

As noted above, the objective is to recover an appropriate amount of the costs of providing regulatory services, having regard to equity, efficiency and effectiveness.

Regulatory fees and user charges should generally be set on a full cost recovery basis; however, if it is determined that full cost recovery is not consistent with other policy objectives, then it may not be appropriate to introduce a full cost recovery regime. The Cost Recovery Guidelines note that ‘efficiency and equity considerations may need to be balanced against each other in determining the appropriate form of cost recovery’.

Consideration may be given to a regime of partial cost recovery (if it can be demonstrated that a lower than full cost recovery does not jeopardise other objectives) and/or rely on other funding sources (for example, general taxation) to finance the government activity.

Accordingly, where social policy or equity considerations are considered to outweigh the efficiency objectives associated with full cost recovery, and/or where full cost recovery might adversely affect the achievement of other government policy objectives, partial or zero cost recovery is to be considered.

The Act requires all private NEPT providers to be licenced and to apply for a licence or a renewal of licence using a prescribed form. It is an offence to operate a private NEPT service without a licence. The Act provides for a licence to be issued for 2 years unless the Secretary of the Department forms a view that it should be issued for a shorter or longer period. The Act provides for the licence fees to be prescribed by the Regulations. Any application to the department for a licence, renewal of licence, or variation of licence is required to be accompanied by the prescribed fee. The Act does not provide any direction on how fees are to be set. It is a matter left to the Regulations. Therefore the fee categories for licencees are determined through the Regulation making process, including the public consultation.

The fees prescribed under the 2005 Regulations are based on full cost recovery calculated at the time of the introduction of the regulations, and are graduated according to the number of vehicles operated by a licencee. These are shown in Table 4.2 below

#### Table 4.2 Fees prescribed under the 2005 Regulations

#### Application Fees

|  |  |  |
| --- | --- | --- |
| Application type | Fee ($) | Fee units |
| Application for approval in principle (AIP) | 1713.60 | 126 |
| Application for variation or transfer of AIP | 380.80 | 28 |
| Application for non-emergency patient transport licence |  |  |
| 0-9 vehicles | 652.80 | 48 |
| 10-19 vehicles | 2094.40 | 154 |
| 20-29 vehicles | 3400.00 | 250 |
| 30-39 vehicles | 4569.60 | 336 |
| 40-49 vehicles | 5997.60 | 441 |
| 50+ vehicles | 7303.20 | 537 |
| Surcharge per aircraft | 136.00 | 10 |
| Application for variation of licence | 1115.20 | 82 |
| Stand-by accreditation | 448.80 | 33 |
| **Fees for renewal of licence** |  |  |
| Number of Vehicles |  |  |
| 0-9 vehicles | 652.80 | 48 |
| 10-19 vehicles | 2094.40 | 154 |
| 20-29 vehicles | 3400.00 | 250 |
| 30-39 vehicles | 4569.60 | 336 |
| 40-49 vehicles | 5997.60 | 441 |
| 50+ vehicles | 7303.20 | 537 |

The fees were based on the number of vehicles in operation at the time of the introduction of the Regulations. The number of vehicles in operation has since more than doubled and therefore it is not considered that this is an equitable way to calculate fees for the new regulations. All options considered therefore have been based on the cost of undertaking the assessment of the applications which includes cost of inspections.

As the department is moving to a risk based approach in the application of the Regulations there will no longer be routine inspections of NEPT licencees. Instead the unit will review a range of data, reports and complaints to determine need and frequency of regulatory inspections of licencees. Inspections will be carried out where patient safety risks or underperformance are identified.

The Act sets out the matters the Secretary of the Department must take into account in deciding whether or not to grant or renew a licence. These are:

* in the case of an applicant who is a natural person, whether the applicant is a fit and proper person.
* in the case of a body corporate whether each director and officer is a fit and proper person.
* the suitability of the equipment and vehicles to be used in the service.
* whether or not there are operating arrangements for the management and staff that are suitable and comply with the regulations.
* whether or not there are arrangements for maintaining the quality of the service that are appropriate.
* whether or not there are arrangements for evaluating, monitoring and improving the quality of the service that are appropriate.
* whether or not the service operated under the licence (to be renewed) complies with the Act, the regulations and any other law relating to or affecting the operation of the service.
* whether the prescribed application fee has been paid.

The Act further sets out he matters to be considered in determining whether a person is a fit and proper person. These are:

* whether the person has been found guilty of an offence against the Act.
* whether the person is of sound financial reputation and stable financial background.
* whether the person is of good repute.
* whether the person has been found guilty of an indictable offence or an offence involving dishonesty, fraud, or drugs trafficking in the previous 10 years.

For all options considered fees have been calculated using an activity based costing approach. Each activity undertaken by the department in assessing applications is designed to enable the Secretary to meet the obligations set out above. Each activity required to be undertaken by the Department to consider each type of application have been costed and allocated to the various prescribed fees. The administrative functions have been applied as a flat fee to all licences with a further variable component based on estimated time required to regulate the licencees. These are set out in appendix A2.It is noted that the Ombudsman, in her 2015 report into Mentone Gardens Supported Residential Service, made adverse findings against the department in relation to its assessment of the financial capacity of the operator, the fitness and propriety of the operator and the criminal history of the operator when renewing the licence to operate. The department has the same responsibilities in relation to NEPT licencees and has a statutory responsibility to ensure these matters are thoroughly assessed for any application for a licence or a renewal of a licence. The processes and activities undertaken to assess the licence applications are considered to be the most efficient and effective possible within the constraints of overall departmental systems. The processes are continually reviewed and updated to improve efficiency and effectiveness.

The activity based costing for NEPT licence fees cannot be benchmarked against other States. Only South Australia charges a fee to licence private NEPT providers which is a nominal amount of $150 annually and which was not based on an activity based costing analysis.

The activity based approach has therefore been modelled on the approach used in the Regulatory Impact Statement for the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013.

Option A, the proposed Regulations, prescribes licence fees based on full cost recovery. Fees have been allocated to small operators (less than 10 vehicles), medium sized operators (10-50 vehicles), and large operators (50+ vehicles).

Option B, the current Regulations, prescribes fees at 50% of the cost to the Department of providing the service.

Option C proposes a flat fee for each licencee irrespective of the number of vehicles operated by the licencee. It does not take into account any equity considerations based on the size of the licenced entity.

For each option the licence fees in the Regulations will be expressed as fee units. The Government increases the value of fee units annually (1 July each year) as advised by the Department of Treasury and Finance. The value of a fee unit in 2015-2106 is $13.60.

## 4.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options reflecting the Cost Recovery Guidelines. The criteria used were:

* efficiency — fees set at a level to promote the efficient allocation of resources
* effectiveness — fees set at a level to achieve the government’s policy objective
* equity — fees set at a level to promote the sharing of costs and benefits across society.

Accordingly, the ‘efficiency’, ‘effectiveness’ and ‘equity’ criteria were each assigned a weighting of 33 per cent, reflecting their overall importance in achieving the government’s policy objectives in relation to fee setting.

#### Table 4.2 Multi-criteria analysis criteria and weightings

|  |  |
| --- | --- |
| Criterion | Weighting |
| Efficiency | 33% |
| Effectiveness | 33% |
| Equity | 33% |

### The cost of licencing

The cost base for the purposes of assessing cost recovery is based on the incremental costs associated with the department administering the Act as it relates to approval in principle and licencing applications and associated tasks. An activity-based costing method was used to determine the fee for each individual activity.

These tasks were examined along with the cost of staff time (incorporating on-costs and overheads) in undertaking these tasks. These are fully described in Appendix A 2. The amounts in Table 4.3 below show the costs to government associated with each element of licencing.

#### Table 4.3 Costs of licencing per annum to Government

|  |  |  |
| --- | --- | --- |
| Activity | Average number completed per year | Projected revenue from full cost recovery / year $ |
| Approval In Principle (AIP) | 0 | 0 |
| Variation or transfer of AIP | 0 | 0 |
| Licence fee (initial) | 2 | 5,032.00  |
| Licence renewal (Average)  | 10 | 28,110,00  |
| Variation of licence  | 1 | 612.00  |
| Transfer of Licence | 1 | 612.00  |
| Stand-by Accreditation | 7 | 4,188.80 |
| **TOTAL** |  | **38,554.80**  |

Once a NEPT service is licenced, it is required under the Act to apply for a licence renewal every two years, for which there is a fee. Before the licence is renewed a risk based review is undertaken, and an inspection by a senior nurse advisor is carried out if deemed necessary, to ensure the licencee is compliant with the Regulations.

Licence fees are intended to generate sufficient revenue to offset the costs of the all services provided to the industry by the Department. These include the cost of the department’s monitoring and inspection services, enforcement, service planning and the enhancement of information systems. The licence fee is variable, determined by the number of vehicles operated by a NEPT service. The greater the number of vehicles, the higher the licence fee.

On analysis, there is no evidence that larger NEPT services impose a higher administrative cost on the department than smaller ones for processing licence applications. Inspections of larger services take longer as there is more information to review, however these NEPT services are also more likely to have sophisticated business or quality systems, and be less reliant on advice or guidance by the department.

The fee base under the 2005 Regulations has been structured to achieve vertical equity. This is to ensure those with greater means contribute proportionally more than those with lesser means.[[10]](#footnote-10) While this approach is continued the variation between the fees in the proposed Regulations has been reduced when compared to the 2005 Regulations.

The proposed fees represent the total licencing cost to the department to provide NEPT services required by the Act for all licenced NEPT businesses over the two year licence cycle.

### The base case

As explained in section 3.2 the base case of (no regulations) of no prescribed licence application and renewal forms and no prescribed fees would mean the NEPT sector could not operate. However for the purposes of this RIS it is assumed that NEPT operators can be licenced and this section will examine the options for setting licence fees.

The base case of no prescribed fees would result in the work of the regulator being entirely funded by taxpayers. This would be contrary to Government policy of full cost recovery of services delivered by the Government.

Not all taxpayers use NEPT services and so the result of full taxpayer funding of the regulatory services would be that the users of the services and the services themselves would be subsidised by non-users of the service.

The argument about community benefit being a justification for some parts of the community to subside other parts usually applies to Government provided services such as the police and the fire services. It does not usually apply to the regulation of privately operated services. Paying for the cost of regulation is a cost of doing business and one that should be carried by those private businesses that are being regulated.

Therefore the base case is not a feasible option.

The cost of the base case is zero as no fees would be charged.

### Option A: the proposed Regulations – variable fee at full cost recovery

The Cost Recovery Guidelines state that the general government policy is that regulatory fees and user charges should usually be set on a full cost-recovery basis. In this case, full costs represent the value of all the resources used or consumed in the provision of licencing, and the associated monitoring and compliance arrangements.

Option A sets licence fees on the basis of a combination of a fixed administrative component that applies to all licencees irrespective of size, and a variable component determined by vehicle numbers which is a proxy for the estimated time required to undertake regulatory activities. The total income required by the Department to offset their activities was determined and then divided by the number of businesses to get an average figure (this is Option C). That figure was then adjusted according to the number of vehicles (see table 4.4) operated by a business with a $2,000 increase for each category. This was done to achieve vertical equity while covering the cost to the department.

As stated earlier the larger the business the more time required for the regulatory oversight. Setting fees on a sliding scale linked to the size of the business reflects the degree of regulatory oversight of the business required from the department. For example under the proposed Regulations the department will review the outcomes of accreditation audits, patient death reports, complaints and annual reports as part of the risk analysis process. The larger the business the more time will be required to review the documents and engage with the business to resolve any outstanding matters. The fee structure reflects these requirements.

As explained earlier vertical equity is a consideration in the setting of licence fees. Multi-million dollar businesses, such as the larger NEPT businesses have a greater capacity to pay.

Examples of NEPT business turnover:

A NEPT business with 5 vehicles undertaking 8 transports per day (excluding weekends) per vehicle at $200 per transport turns over $8,000 per day or about $1.9 million per annum.

A NEPT business with 20 vehicles undertaking 8 transports per day (excluding weekends) per vehicle at $200 per transport turns over $32,000 per day or about $7.6 million per annum.

A NEPT business with 50 vehicles undertaking 8 transports per day (excluding weekends) per vehicle at $200 per transport turns over $80,000 per day or about $19 million per annum.

A registration fee, payable once every 2 years of $1808, $3,808, and $5,808 respectively, is negligible in comparison to income.

Table 4.4 lists the proposed fees which reflect the costs to government for each activity.

#### Table 4.4 Projected fees at 100% revenue recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Proposed Fee | Average number completed per year | Projected revenue from full cost recovery / year |
| Approval In Principle (AIP) | 1,727.20  | 0 | 0 |
| Variation or transfer of AIP | 557.60  | 0 | 0 |
| Licence fee (initial) | 2,516.00  | 2 | 5,032.00  |
| Licence renewal  |  | 10 | 28,110.00 |
| 1-9 Vehicles | 1,808.80  |  |  |
| 0-49 Vehicles  | 3,808.00  |  |  |
| 50+ Vehicles  | 5,807.20  |  |  |
| Variation of Licence  | 612.00  | 1 | 612.00  |
| Transfer of Licence | 612.00  | 1 | 612.00  |
| Stand-by accreditation | 598.40 | 7 | 4,188.80 |
| **TOTAL** |  |  | **38,554.80**  |

If the proposed cost recovery fees are applied, the total revenue for the department would total $38,554.80 which is equivalent to the cost of providing the service – see Table 4.3.

Counter intuitively the licence renewal fee is slightly more expensive than the initial licence fee. This is because the licence renewal includes review of the history of the applicant, review of the annual report and review of the prescribed elements of the quality assurance plan.

Given that full cost recovery is the most economically efficient option for fee levels and fully achieves the government’s objective on efficiency grounds, a maximum score of 10 is assigned to this criterion.

In terms of ‘effectiveness’, it is not believed that the full cost recovery fees would result in higher rates of noncompliance, or act as a barrier to entry to new health service establishments, however it is not as effective as a zero fee. Therefore effectiveness has been scored 5.

Equity has been scored at +2 because the fees charged for renewal of licence have been adjusted according to the relative capacity of the licencee to pay. Therefore the smaller businesses pay less than the larger businesses. However the discrepancy between the fees is not as large at the current licence fees.

This results in a net score of +5.61. Table 4.5 summarises the scoring.

#### Table 4.5 MCA variable fees at full cost recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Efficiency | 33% | +10 | +3.3 |
| Effectiveness | 33% | +5 | +1.65 |
| Equity | 33% | +2 | +0.66 |
| **TOTAL** | **100%** |  | **+5.61** |

### Option B: Variable fee at partial cost recovery

The proposed regulations represent partial cost recovery. This option reduces the cost to the sector of doing business. The proposed fees and percentage recovery for each is noted below in Table 4.6

#### Table 4.6 proposed fees and percentage recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Cost to government per year per licence | Proposed Fee | % recovery |
| Approval In Principle (AIP) | 1,727.20 | 863.60 | 50 |
| Variation or transfer of AIP | 557.60 | 278.80 | 50 |
| Licence fee (initial) | 2,516.00 | 1,258.00 | 50 |
| Licence renewal |  |  | 50 |
| 1-9 Vehicles | 1808.80 | 904.40 |  |
| 0-49 Vehicles  | 3,808.00 | 1,904.00 |  |
| 50+ Vehicles  | 5,807.20 | 2,903.60 |  |
| Variation of licence  | 612.00 | 306.00 | 50 |
| Transfer of Licence | 612.00 | 306.00 | 50 |
| Stand-by Accreditation | 598.40 | 299.20 | 50 |

\* Fees are linked to government fee units which are updated annually.

#### Table 4.7 Average revenue per year from proposed fees

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Proposed Fee | Average number completed per year | Projected revenue from partial cost recovery / year |
| Approval In Principle (AIP) | 863.60 | 0 | 0 |
| Variation or transfer of AIP | 278.50 | 0 | 0 |
| Registration fee (initial) | 1,258.00 | 2 | 2,516.00  |
| Registration renewal (Average)  | 1,405.50 | 10 | 14,055.00  |
| Variation of registration  | 612.00 | 1 | 306.00  |
| Transfer of Registration | 612.00 | 1 | 306.00  |
| Stand-by Accreditation | 299.20 | 7 | 2,237.20 |
| **TOTAL** |  |  | **19,420.20**  |

The percentage recovery of the proposed fees is 50%. If the proposed cost recovery fees are applied, the total revenue for the department would total $19,420.20 p.a.

Partial cost recovery seeks to balance the efficiency objective against the equity objective, while ensuring that the government’s overall policy objectives are not jeopardised.

The efficiency criterion is positive because proprietors would still make a contribution towards funding the regulation of the industry. Given that the proposed Regulations will result in 50 per cent less revenue, a score of 50 per cent less for this criteria has been given +5.

The effectiveness and equity criteria received the same score as option A as the relativities are the same.

This results in an MCA score of +3.96, as noted in Table 4.8 below.

#### Table 4.8 MCA scores for Option B: partial cost recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted Score |
| Efficiency | 33% | +5 | +1.65 |
| Effectiveness | 33% | +5 | +1.65 |
| Equity | 33% | +2 | +0.66 |
| **TOTAL** | **100%** |  | **+3.96** |

### Option C – A flat licence fee at full cost recovery

A flat licence fee means that every licencee pays the same amount irrespective of the size and scope of their business. As described in “The cost of licencing” there is no evidence that larger NEPT services impose a higher administrative cost on the department than smaller ones. While inspections of larger services will take longer and there can be more information to review, they are also more likely to have sophisticated business or quality systems, and therefore be less reliant on advice or guidance by the department and tend to have fewer follow-up inquiries.

Option C therefore does not include equity in its calculations of the proposed licence fee. It operates on the assumption that any entrant to the market can afford the fees required to cover the regulatory oversight of the cost of their business and does not provide for any cross subsidisation among the licenced businesses.

The only difference between Option A and Option C in practice is the cost of the licence renewal for applicants. The overall income for the department is the same.

Given that full cost recovery is the most economically efficient option for fee levels and fully achieves the government’s objective on efficiency grounds, a maximum score of 10 is assigned to this criterion.

In terms of ‘effectiveness’, it is not believed that the full cost recovery fees would result in higher rates of noncompliance, or act as a barrier to entry to new health service establishments, however it is not as effective as a zero fee. Therefore effectiveness has been scored 5.

Equity has been scored at 0 as it is not an element incorporated into the analysis as the fees are set at a flat rate irrespective of any other consideration.

#### Table 4.9 MCA scores for Option C: flat fee at full cost recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted Score |
| Efficiency | 33% | +10 | + 3.3 |
| Effectiveness | 33% | + 5 | +1.65 |
| Equity | 33% | 0 | 0 |
| **TOTAL** | **100%** |  | **+4.95** |

#### Table 4.10 Projected fees on a flat fee basis

|  |  |  |  |
| --- | --- | --- | --- |
| Activity | Proposed Fee | Average number completed per year | Projected revenue from full cost recovery / year |
| Approval In Principle (AIP) | 1,727.20  | 0 | 0 |
| Variation or transfer of AIP | 557.60  | 0 | 0 |
| Licence fee (initial) | 2,516,00  | 2 | 5,032.00  |
| Licence renewal | 2,811.00  | 10 | 28,110.00  |
| Variation of Licence  | 612.00  | 1 | 612.00  |
| Transfer of Licence | 612.00  | 1 | 612.00  |
| Stand-by accreditation | 598.40 | 7 | 4,188.80 |
| **TOTAL** |  |  | **38,554.80**  |

Note: All fees have been rounded to the nearest fee unit

## 4.6 The preferred approach

Based on the analysis, the department considers that the proposed Regulations (Option A) are preferable to the alternative options assessed, as shown in Table 4.13.

Cost of initial licencing per facility is $2,516

The cost of renewal of a licence is, on average, $2,811

In order to meet the Department’s costs for assessing renewals of licences the total income must be $2,811 x 20 = $56,220 over 2 years.

#### Table 4.11 Proposed licence renewal fees

|  |  |  |  |
| --- | --- | --- | --- |
| Vehicle numbers | No. of licencees | Licence fee | Total income |
| 1-9 | 13 | $1,808.80  | $23,514.40  |
| 10-49 | 4 | $3,808.00  | $15,232.00  |
| 50+ | 3 | $5,807.20  | $17,421.60  |
| **Total** |  |  | **$56,168**  |

Total fees charged per annum are:

1 x $2,516 (initial licence fee) + 10 x $2,811 (annual renewal fees for half the licencees) + 1 x $612 $633 (variation of registration) 1 x $612 (transfer of registration) + 7 x $598 (1 new and 6 renewed stand-by accreditation fees)

= $2,516 + $28,110 (median) + $612 + $612 + $4,186

**= $36,036 p.a.**

#### Table 4.12 Proposed fees (rounded to the nearest fee unit)

|  |  |  |
| --- | --- | --- |
| Application type | Fee ($) | Fee units |
| Fee for application for approval in principle (AIP) | 1,727.20  | 127  |
| Fee for variation or transfer of certificate of AIP | 557.60  | 41  |
| Application for Licence | 2,516.00  | 185  |
| Renewal of Licence |  |  |
| 0-9 vehicles | 1,808.80  | 133  |
| 10-49 vehicles | 3,808.00  | 280  |
| 50+ vehicles | 5,807.20  | 427  |
| Application for variation or transfer of licence | 612.00  | 45  |
| Stand-by accreditation application or renewal | 598.40 | 44 |

#### Cost to the sector of applying for a licence

The cost to the sector to apply for a licence or licence renewal is $4,765 per annum or $433 per application. See Appendix A 2, Table A 2.11.

The total costs comprise $36,036 (licence fees) and $4765 (licence application costs) = $40,081 pa.

The 10 year discounted cost is $469,879 - See appendix A, Table A 2.12

As recommended by the Victorian Guide to Regulation[[11]](#footnote-11), a symmetric scoring scale ranging from -10 to +10 was used because it is simple to apply and understand, as well as allowing enough scope for differences across options to be distinguished.

#### Table 4.13 Summary of MCA scores for options

|  |  |
| --- | --- |
| Option | MCA score |
| Option A – Variable fee at full cost recovery | +5.61 |
| Option B – Variable fee at partial cost recovery | +3.96 |
| Option C – Flat fee at full cost recovery | +4.95 |

As per the scores noted above in Table 4.14, Option A, variable fees at full cost recovery, is the preferred option.

# 5. Patient Acuity Assessments

## 5.1 The nature and extent of the problem to be addressed

The assessment of patient acuity is a critical element in determining which vehicle and crew should be allocated to the transport. In the absence of a patient acuity assessment it would be expected that vehicle and crews allocated would not always match the clinical needs of the patient thereby leading to adverse outcomes for some patients. There would be a cost associated with this scenario which has been analysed as part of the base case.

## 5.2 Objectives

The objective of this regulation is to ensure all patients requiring NEPT transport can be sent an NEPT vehicle that is appropriate to their needs, and not an emergency vehicle.

The secondary objective is to reduce the demand on emergency vehicles by ensuring the regulatory structure does not prevent NEPT patients being allocated an NEPT vehicle.

An indirect objective is a reduction in ambulance Code 1 response times. Achievement of the secondary objective is also expected to have a positive impact on other Government objectives not directly related to the Regulations such as improving timelines of NEPT transports, reducing bed blocking in hospitals and reducing ambulance ramping at hospital emergency departments.

## 5.3 Interstate arrangements

Assessment of acuity in other states, excluding calls to triple zero, is carried out by the following:

NSW - medical practitioner or a division one registered nurse

Queensland – medical practitioner

South Australia – medical practitioner

Tasmania – medical practitioner

Western Australia – St John Ambulance clinicians

Victoria is currently the only State that cannot allocate medium and high acuity NEPT transports from calls to triple zero. This is due to the regulatory constraints imposed by the 2005 Regulations.

## 5.4 Identification of options

### Table 5.1 Regulatory options

|  |
| --- |
| Option A: Broader patient acuity assessment – the proposed regulations |
| The assessment of patient acuity may be undertaken by a medical practitioner, a division one registered nurse, and a clinician (Division one registered nurse or paramedic) employed by AV. |
| Option B: Medical Practitioner only patient acuity assessment – the alternative regulatory approach |
| The assessment of medium and high acuity patients must be by a medical practitioner. Option B is a continuation of the current regulated. Under this arrangement where a medical practitioner is not available to assess patient acuity an emergency vehicle must be dispatched |

It is arguable that the current NEPT arrangements in legislation have made AV less efficient. This is because of the requirement that only a medical practitioner can assess medium and high acuity patients. As AV does not employ medical practitioners to make these assessments the practical effect of the requirement has been to make AV the default patient transport service, whereas prior to the introduction of the legislation the NEPT service was the default patient transport service. The outcome has contributed to the decline in Code 1 response times. AV modelling against their 2013-2014 data indicates that the emergency ambulance service is providing at least 50,000 transports per annum that could be adequately provided by NEPT services.

Under the current patient transport scheme NEPT transport can be delayed at times. Provided the NEPT patient is stable the delayed transport is an inconvenience rather than an adverse impact and so has not been included in the cost analysis. It is noted that delays in NEPT may result in some patients missing medical appointments, or departure from a hospital, however there is no data to measure the degree to which this occurs. Therefore it has not been included in the cost analysis of the options.

Option A takes a broader approach to patient acuity assessment by expanding the range of appropriately qualified people who can assess patient acuity in order for an NEPT transport to be allocated compared to the current regulations.

The broader approach recognises the reality of the situation “on the ground” where AV, aged care and disability care facilities do not employ medical practitioners but do employ Division 1 registered nurses and/or paramedics who are medically qualified to assess the acuity of patients.

Option B is a continuation of the current regulatory approach applied to assessment of patient acuity for medium and high acuity patients. It specifies that a medical practitioner must assess the acuity of medium and high acuity patients in order for a NEPT vehicle to be allocated. This is the more common approach taken nationally.

No other viable option for assessment of patient acuity has been identified. Each option considered was equivalent to either the base case or options A & B. Therefore no third option is considered in the RIS.

## 5.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 5.2 below.

**Table 5.2 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Protecting the service users through effective assessment of patient acuity  | 50% |
| Costs or saving arising from the measure | 50% |

These criteria reflect the objectives of the Regulations as they relate to the identified problem in this RIS about having appropriate staff assess patient acuity to ensure the most appropriate vehicle and crews provide the transport.

Because providing for the safety and quality of care of service users is the primary objective of the Regulations, the effective assessment of acuity is accorded a criteria weighting of 50 per cent. The overall costs imposed by the regulations or the savings resulting from the regulations are weighted at 50 per cent to ensure that costs and benefits to patients and the broader community are given balanced consideration in the analysis.

The analysis is incremental as the current regulations require the acuity of medium and high acuity patients to be assessed by a medical practitioner. The remainder of patients (low acuity) are currently assessed by ESTA and AV via triple zero calls. What is proposed under the new regulations is an incremental move to expand the low acuity assessment approach to all NEPT patient acuities. This incremental shift will create efficiencies in patient transport overall.

The base case and option A will allow for greater flexibility in who may assess patient acuity and will therefore result in more patients being assigned to NEPT transport than is currently the case. Ambulance Victoria (AV) has reviewed the clinical care records of patients from 2013-2014 and estimate at least 50,000 emergency transports could have been safely managed by NEPT. The 50,000 figure has been derived from modelling the proposed changes against the 2013-2014 patient transport data. The 50,000 number is a realistic guide to the future under the proposed regulations, not a definitive figure. Nevertheless it is evidence based and is therefore appropriate to rely on.

AV modelling estimates show both the base case and option A would result in at least 50,000 emergency vehicle transports annually being diverted to non-emergency vehicles with a consequent positive impact on NEPT punctuality and emergency ambulance response times for the broader community.

However the base case would permit anybody to assess patient acuity, whether or not they were qualified to do so. Examples could be hospital ward staff, administrative staff, finance staff, and clerical staff. A significant risk to the health of patients would result if unqualified people were permitted to assess patient acuity, potentially increasing rates of death, harm or injury during transport. Therefore in order to achieve the community savings outlined while protecting the health and safety of patients Option A is the recommended option.

It is noted that option A would significantly increase demand for NEPT services (with a consequent reduction in demand for emergency ambulance services) and so a transition period may be required in order to allow the private NEPT sector to scale up to accommodate the increased demand (e.g. extra vehicles and staff). AV have advised that their current contracts with private NEPT providers allow for scaling up in anticipation of this change.

Removing more than 50,000 trips per annum from the emergency ambulance service will result in an estimated 10% improvement in the availability of current AV emergency road transport fleet which is expected to result in an improvement of emergency ambulance response times. Increased availability will allow triple zero operators to locate a dispatch a vehicle to Code 1 patients more quickly resulting in an improvement in response times.

Ambulance response times also depend on the proximity of an ambulance to the location of the patient at the time the triple zero call is received. Many people who live on the outer metropolitan fringes and in rural areas live further than 15 minutes from an ambulance depot or hospital, so while response times will reduce for these people they will still be outside the 15 minute target for Code 1 responses.

It is assumed the improved response times will result in at least 2 lives saved per annum (the rationale for the assumption is explained under Option A). There may also be reduced adverse events as a result of the change.

The two options put forward as in this assessment are considered to be the only two workable regulatory options. Apart from medical practitioners, division one registered nurses and paramedics there are no other groups of medical professionals working in the NEPT sector where all members would have the expertise to assess patient acuity.

**Note**: Medical practitioner is defined as the list of specialities, fields of specialty practice, and related specialty titles approved by the Medical Board of Australia.

For the base case and the options the costs or savings are community costs of saving and do not directly impact on compliance costs for NEPT licencees. This is because it is not the NEPT licencees that determine acuity and therefore determine which vehicle they will send. It is a decision of the facility requiring the transport and it is that facility or the patient that pays for the transport. The NEPT licencee charges according to its contracted or listed schedule of fees. Therefore the MCA cost scores are based on community coast rather than costs incurred by the NEPT licencees.

### The base case

The base case in this section is taken as a scenario where the private NEPT providers are licenced to operate but have no regulations of obligations linked to operations. Under the base case there would be no restrictions on who could assess patient acuity for NEPT transport.

In the absence of Regulations, it is reasonable to expect that ‘business as usual’ would still see the vast majority of patients’ acuity assessed appropriately due to:

* The need to ensure patient safety;
* maintenance of the reputations of the private service providers.

However, for planned transports not organised through AV, there would be potential for patient risk if the acuity assessment was undertaken by staff who were not medically qualified to do so. Examples may be administrative staff in hospitals or residential accommodation, some Division 2 registered nurses, personal care assistants, etc.

In this scenario there is a risk of unsuitable vehicles and crews being allocated to the patient transport. There is a risk to the patient if a crew and vehicle are not competent to manage the patient’s medical needs. This situation may result in a second vehicle and crew being called out or a crew being unable to manage a patient’s medical condition during the transport. Delays created by an incorrect patient assessment may also lead to adverse outcomes for the patient. Alternatively there may be increased costs if staff take a risk averse approach and allocate a vehicle and crew with competency to manage a higher risk patient than the patient requiring the transport. The department has been advised that in practice there is minimal cost difference between vehicles of differing acuity.

As this is a hypothetical situation and there is no data to inform the assessment it has been assumed that both scenarios are equally likely. It is noted that these scenarios are extreme and would not be the norm. There would be strong drivers, such as reputational risk of the hospital and treating medical practitioners, for processes to be put in place in the absence of regulation, to ensure patient acuity was assessed by appropriately qualified staff. For triple zero calls and planned AV bookings there would be appropriate allocation of transport vehicles and crews in most instances as the AV clinician would be expected to assess the patient acuity correctly based on the reported symptoms, however incorrect assessments can occur. Absence of regulation would not be expected to have any impact on the rate of incorrect assessments as these are caused by incorrect information and human error.

If any health facilities allowed non clinical staff to request patient transports and make the assessment of patient acuity (without medical direction) there would be potential for incorrect assessments to be made as a result.

The costs that have been calculated for the base case are based on the patient risk and additional cost incurred if acuity is incorrectly assessed and exclude triple zero calls and planned AV transports. As there is no data on how many transports may be mis-allocated assumptions have been made in undertaking the analysis. These assumptions are explained below.

Patient risk would arise if there are no controls over who can assess acuity. For the triple zero calls and booked AV transports patient acuity would continue to be assessed by the same staff and so there would not be any increased risk for those patients. Therefore no cost is attributed to adverse events following a triple zero or AV booking vehicle allocation as it would be unchanged from the current situation.

For those patients being sent from aged care, disability care, or from hospitals directly without using AV, the assessment of patient acuity would be dependent on the policies and procedures of the facility. While in most instances appropriately qualified staff would be expected to be delegated to assess patient acuity there is the potential for unqualified staff (not a medical practitioner or a division one registered nurse) to be given the responsibility to assess patient acuity. If so there is a clear risk to patients as the person assessing the patient acuity may not be appropriately qualified to do so. In this situation there is a greater risk of patient acuity being incorrectly assessed.

Alternatively staff may request a higher acuity vehicle than is needed as they overcompensate in managing the patient risk. In this scenario the additional cost is borne by the sending facility, not the NEPT service.

The base case therefore assumes that 5% of patient acuity assessments excluding ESTA and AV assessments would be incorrectly assessed. These assessments are made by hospital staff and aged care and disability staff. While most facilities and all hospitals would employ Division 1 registered nurses and most would ensure patient acuity assessment would be carried out by the nurses it cannot be assumed that every facility would do this. In any industry mistakes can be made, some businesses are under financial pressure and may not be able allocate sufficient resources to all activities, and some businesses may choose not to. The 5% estimate takes account of this likelihood. Licencees consulted with have indicated that they believe that the estimate is realistic.

The costs associated with the base case have been calculated as follows.

#### Cost of allocating a second vehicle:

Adverse events are incidents in which harm has resulted to a person receiving health care. They include infections, falls resulting in injuries, and problems with medications and medical devices. Some of these adverse events may be preventable.[[12]](#footnote-12)

There is no data to base calculations of adverse patient outcomes on. The rate of adverse events in Victorian public hospitals in 2003-4 was 6.88%.[[13]](#footnote-13) A rate of 2% adverse patient outcomes for the reallocated transports has been assumed for those patients where a second vehicle must be called. Only low and medium acuity patients are affected in this scenario as a second vehicle would not be required for high acuity patients as a high acuity vehicle would be suitably equipped and staffed for any NEPT transport. It is expected there would be a lower rate of adverse events than in hospitals as no medical procedures have taken place. Each adverse event was costed at $6,825[[14]](#footnote-14) in 2004 using the cost of an adverse event occurring in Victorian public hospitals as the proxy. Allowing for inflation since then[[15]](#footnote-15) the actual cost is now $8,960.

It is noted that AV report that there were about 400 adverse events in their NEPT transport in 2013-2014.

Industry data provided to the department show that 75% of non AV NEPT is for low and medium acuity patients. Contract costs charged by private NEPT providers are commercial in confidence and therefore not available to the department to publish. Advice from the sector is the non AV transports for medium and high acuity patients is charged at about $200 per trip. The actual cost varies according to distance travelled, the degree of monitoring required and urgency of the transport.

The estimated cost of sending a second vehicle under the base case assumptions is:

##### 2.5% x (75% x 200,000) (non AV medium and high acuity transports) x $200 (metro NEPT vehicle cost) = $750,000 per annum.

##### Cost of adverse patient outcomes:

2% x (2.5% x 75% x 200,000) x 8,960 = $672,000

#### Cost of allocating a crew and vehicle with competence and equipment in excess of the patient’s medical needs:

The department has been advised that there is usually no additional cost for a higher acuity vehicle.

Note: no additional adverse events would result from this outcome.

#### Total Cost of the base case

$750,000 + $672,000 = $1,422,000 per annum

Note: these costs are incurred by either the sending health facility or the patient and are not incurred by the NEPT provider.

### Option A: the proposed Regulations

Currently the Regulations require that for a medium and high acuity patient a medical practitioner must assess the patient acuity. The Emergency Services Telecommunications Authority (ESTA) does not employ medical practitioners to take the triple zero calls. ESTA uses AV registered nurses and paramedics to assess NEPT patient acuity. The current regulations do not permit people with these qualifications to make medium and high acuity patient assessments. As a result any patient that is assessed as medium or high acuity is sent an emergency vehicle for the transport. The current scenario can result in some unpredictability and long waits for some patients who have dialled triple zero and require non-emergency transport. If the allocated emergency vehicle is redirected to a Code 1 incident en route another vehicle must be allocated to the patient when it becomes available.

For those patients that are booked a transport from an aged care or disability care facility through the AV booking service a similar situation can occur. AV also uses registered nurses and paramedics to assess acuity over the phone when the booking is made. As neither AV nor the facility employs a medical practitioner, for all patients assessed as medium or high acuity, an emergency vehicle is dispatched. AV estimate that approximately 4,000 trips annually occur in this manner. As described above there can be long waits for patients if the allocated vehicle is redirected to a Code 1 incident.

Ambulance Victoria (AV) has reviewed the clinical care records of patients from 2013-2014 and estimate that more than 50,000 emergency transports could have been safely managed by NEPT.

If the AV estimate is accurate Option A will result in an increase the size of the private NEPT sector necessitating the purchase of at least 39 extra vehicles[[16]](#footnote-16) and the employment of associated extra staff. As this is a business opportunity with discretionary expenditure and is not required by the Regulations the cost of the additional vehicles and staff have not been incorporated into the cost calculations.

The cost of permitting patient acuity to be assessed by medical practitioner, a Division 1 registered nurse, and clinicians employed by AV is zero as the organisations with responsibility for organising patient transfers employ people in these roles for other reasons. If these people were not permitted to assess patient acuity arguably it would increase costs for the affected organisation due to the need to employ a specific person to undertake the task. Therefore the cost of the proposed Regulations is zero.

There are significant savings associated with the Regulation when measured against the current regulations. There are also savings when compared against the base case.

AV advise that identifying all transports potentially able to be moved to NEPT at the point of call taking will not be possible under current arrangements as these cases are spread across a number of case types. However, there are a number of case types that have a significant percentage of transports that could be safely managed by NEPT. As part of its proposed agenda of reform AV is proposing to pass these cases through to Referral Service for secondary triage. The Referral Service will be better able to identify those cases that are suitable for transport by NEPT. AV estimate that initially approximately 50,000 emergency cases will be able to redirected to NEPT.

This redirection capability will:

* Better align AVs response with the patient acuity,
* Allow appropriate non-emergency management of a number of patients (e.g. stable patients with pain),
* Reduce the number of 000 calls for which an emergency ambulance is dispatched,
* Increase availability of emergency ambulances by approximately 10% which will flow on to improved Code 1 performance; and
* Reduce the cost of improving emergency ambulance availability, i.e. introducing new emergency teams.
* Reduce bed blocking in hospitals
* Reduce ambulance ramping at hospital emergency departments

The Herald Sun reported on 24 October 2013 that 5 people had died in Gippsland in the previous 6 months while waiting for an ambulance. If this outcome was repeated across all rural regions over 12 months the number of deaths would be 40 people. On 28 October 2013 The Age reported another 4 people had died waiting for an ambulance. The majority were cardiac arrests and all were in regional Victoria. In each incident the response took longer than the 10 minutes recommended for cardiac arrests and longer than the 15 minute target. It is reasonable to assume there would be additional similar incidents that were not reported in the media.

The Sydney Morning Herald reported in December 2014 that 3 patients had died that month in Sydney while waiting for an ambulance.

It would be expected that any reduction in demand for emergency vehicles would enable a quicker response to both cardiac cases and overall. While it is not possible to presume that ambulance delays resulting in the death of patients would cease, and it not possible to know if these patients would have survived with a rapid ambulance response, it is noted that if just 2 lives were saved each year and the patients lived for an additional 10 years as a result the overall saving to the community would be significant. The value of a value of a statistical life year[[17]](#footnote-17) was calculated at $151,000 in 2007. Allowing for inflation the value of a statistical life is now $182,170.[[18]](#footnote-18) The saving for the 2 lives described above would therefore be: 2 x $182,170 x 10 = $3,643,400 per annum.

A figure of 2 lives has been chosen to be deliberately more conservative than the number of cases reported in the newspapers referred to above. Data is not kept on potential preventable deaths due to delayed emergency ambulance responses. It is acknowledged no lives or more than 2 lives may be saved in any given year if emergency ambulance response improves.

#### Multi-criteria analysis scores

The proposed Regulations provide assurance that the acuity of non–emergency patients will be assessed by suitably competent and qualified staff. This option will prevent mis-assessment of acuity by unqualified staff and prevent unnecessary dispatch of emergency ambulances to non-emergency patients. As there is presumed to be a correlation between the correct assessment of acuity and the provision of the patient transport vehicle and crew, it is assumed this will strongly contribute towards the provision for safety and delivery of quality care, and as such it is scored +8 for this criterion.

The cost of the base case was calculated at $1,422,000 p.a. which is equivalent to a weighted score of zero. Therefore the cost component of the MCA for option A is scored at +0.5 as the savings for Option A is a $5 million better cost outcome than the base case.

Note: the MCA score is small as the cost for option B is very large and it is necessary to maintain a degree of proportionality.

#### Table 5.3 MCA scores for Option A: the proposed Regulations

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Protecting the service users through effective assessment of patient acuity  | 50% | +8 | +4 |
| Costs or saving arising from the measure | 50% | +0.5 | +0.25  |
| **TOTAL** | **100%** |  | **+4.25**  |

The 10 year discounted community benefit is $41,948,270 - See appendix A 3.

### Option B: the continuation of the current Regulations

Continuation of the current Regulations which require a medical practitioner to assess the acuity of medium and high acuity patients is the more common approach adopted by Australian States. This approach imposes constraints on the Victorian NEPT industry and creates a situation where emergency vehicles become the default transport where there is no medical practitioner to assess the patient acuity. This particularly applies to the triple zero calls and booked patient transports from residential accommodation such as aged care and disability care.

There are an estimated 350,000 NEPT transports annually in Victoria by private providers. More than 50,000 additional transports that could utilise NEPT are being diverted to emergency vehicles due to this requirement which imposes increased direct costs on the patient transport system and creates a lost business opportunity for private NEPT firms. It also results in extended response times by AV to emergencies as some of their vehicles are busy with NEPT transports and also creates uncertainty for NEPT transport timeliness as emergency vehicles can be diverted without notice thus delaying the non-emergency patient transport. In turn this contributes to bed blocking in hospitals which in turn contributes to ambulance ramping in hospital emergency departments.

All the above costs amount to a significant regulatory burden on the health sector and the community more broadly.

If the current regulations were continued with there would be costs to NEPT patients of $573 million over the life of the regulations ($42 million in the first year - see appendix A 3, Table A.3.2) as the cost of providing an emergency ambulance is $523 - $1,690 whereas the cost of providing an AV NEPT service is $309 – $1,146 per trip. In addition there are also costs associated with delayed emergency response times.

For the purposes of this assessment we have assumed 2 preventable patient deaths (see earlier reference to ambulance delays under Option A) per annum resulting from the current Regulations. It is acknowledged that this is likely to be an underestimate. The value of a statistical life is set at $182,170 per year and the cost of an adverse patient outcome is costed at $8,960. As previously explained the cost incurred from ambulance delays per annum is assumed to be 2 x 182,170 x 10 (years of additional life) = $3,643,400.

There is a further cost incurred as the prevented increased use of NEPT vehicles and consequent reduction of AV emergency vehicle availability will mean an opportunity to improve the punctuality of the NEPT patient pick up will be lost. This is of significance for patient pick up from hospitals where patients are either being transferred to another hospital or to home. Improved punctuality of patient pick up would in turn allow hospitals to manage bed turnover more efficiently, reduce bed blocking and increase throughput of patients. In turn this may also reduce ambulance ramping at hospital emergency departments as more beds will potentially be available. However it is acknowledged that there are multiple causes of ambulance ramping and bed blocking and it is noted that there is no data available to estimate what the potential cost savings are. Therefore this element of costing has been excluded from the cost of option B.

The alternative Regulations require that a medical practitioner must assess medium and high acuity patients. While this provides a higher level of training for the acuity assessment it imposes considerable restraints and costs on the emergency ambulance sector as a result. This has been demonstrated to increase waiting times for patient pick up, increase ambulance response times, and has led to worse patient outcomes due to the delays in attendance. This approach does not accord with the Government’s objectives of reducing ambulance response times.

It is the Department’s view that this option has demonstrated risks to patient safety in a limited number of instances and does not offer effective assurance that standards of safety and delivery of quality care will have been met. The department is of the view that this approach does not protect patients as effectively as Option A. Therefore, it is scored +4 for this criterion, compared with +8 for the proposed Regulation.

When the 2005 Regulations were developed these costs were not identified and therefore not costed. With the benefit of experience it is now possible to both identify and quantify the costs associated with the requirement for a medical practitioner to assess medium and high acuity patients.

**Incremental cost of option B (Current Regulations) = $573,008,309** – see appendix A 3, Table 3.2. Note: these are not direct costs incurred by the NEPT licencees but are costs incurred by NEPT patients. The total cost of Option B is assessed as $573 million + $3.6 million =576.6 million.

The cost of the base case was calculated at $1,422,000 p.a. Therefore option B has been scored at -10 for the MCA.

#### Table 5.6 MCA scores for Option B: the current Regulations

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Protecting the service users through effective assessment of patient acuity  | 50% | +6 | +3 |
| Costs or saving arising from the measure | 50% | -10 | -5 |
| **TOTAL** | **100%** |  | **-2** |

## 5.6 The preferred approach

Based on this analysis, the department considers that the proposed Regulations are preferable to the alternative option assessed and to the base case, as shown below in Table 5.7.

#### Table 5.7 Summary of MCA scores for both options

|  |  |
| --- | --- |
| Option | MCA score |
| Option A: the proposed Regulations | +4.25  |
| Option B: the current regulations | -2 |

# 6 Staffing (Vehicle Crewing)

## 6.1 The nature and extent of the problem to be addressed

NEPT patients require clinical monitoring, and at times medical intervention, during their transport. The problem these regulations will address is ensuring that the clinical monitoring and medical intervention is available, safe, appropriate and timely, and does not expose the patients to unnecessary harm.

To achieve such an outcome it is necessary to ensure that the patient is appropriately monitored during the journey by crews that are appropriately skilled and competent to do so.

During the consultation process for the 2005 Regulations, some health services commented on the lack of clarity as to staff crewing configurations then being provided by NEPT service providers for the transport of patients with differing levels of acuity. While there had been no known instances or complaints about inappropriate allocations of staff, regulations were nevertheless made to prescribe the number and qualifications of staff required to attend patients with specified levels of acuity. During the life of the 2005 Regulations no complaints about inappropriate allocations of staff have been received.

The 2005 Regulations are prescriptive and inflexible where they link the prescribed qualifications of staff to the defined acuity of the patient. Arguably crews should be assigned to patients on an as needs basis according to their skills, knowledge and competence.

The 2005 Regulations do not directly address patient safety as they do not require the licencee to demonstrate how monitoring of the patient will occur during the transport. Should patients not be suitably monitored there is a potential risk to them should their condition deteriorate suddenly and unexpectedly.

Section 15 of the Act sets down the criteria the Secretary of the department must consider in determining whether to licence an NEPT service, including:

(2)(a)(ii) whether or not there are operating arrangements for the management and staff of the establishment that are suitable and comply with the Regulations.

The problem to be addressed is how to minimise risks to patients and provide for patient safety and quality during transport.

The importance of NEPT crew staffing and skill mix to the delivery of high-quality patient care and patient outcomes has been acknowledged.[[19]](#footnote-19) As such, ensuring that there is a sufficient number of suitably qualified and experienced staff on duty is essential.

Over the past decade there has been a change in the qualifications that may be attained by the NEPT workforce, including a move towards greater professional specialisation. There has been development in the skill level and qualifications for ambulance transport attendants and ambulance officers. A number of the courses specified in the 2005 Regulations have been superceded by the Degree in Paramedical Science which is not a prescribed qualification. In addition the establishment of the Australian Health Practitioners Regulation Agency to oversight registered health practitioners nationally from 1 July 2010 has provided enhanced protections for patients.

Victoria's Better Skills Best Care Strategy sought to trial ways to improve workforce capacity and utilisation, while also improving quality of outcomes, efficiency and worker satisfaction. The key objective was noted as ensuring:

“The right people with the right skills are in the right place at the right time to deliver quality care to patients.”[[20]](#footnote-20)

## 6.2 Objectives

The objective of this Regulation aligns with the overall objective of the Regulations; that is, to provide for the safety and quality of care of patients during transport by NEPT providers.

Specifically, the objective is to ensure that the standard of care patients receive during transport will meet their clinical needs, is adequate, suitable and timely. The Regulation seeks address the risk that an unregulated market will lead to pressure to retain fewer and less qualified/experienced staff than are necessary to deliver services safely.

## 6.3 Interstate arrangements

Victoria is the only State with an NEPT Act and Regulations and the only State to mandate crew qualifications above the level of a Patient Transport Officer.

**NSW**

The qualifications required by NEPT staff to work for NSW Ambulance Service and the Local Health Districts are set out in the New South Wales Health service specifications for transport providers – NEPT.

The staffing and qualifications requirements are:

**Low acuity**:

Patient Transport Officers (PTOs), who have a Certificate III Pre Hospital Care, Assistant in Nursing or Division 2 nurse

**Medium Acuity**:

PTO and Division 1 or 2 Nurse

**High Acuity:**

PTO and Division 1 nurse

NB: The NSW designations of patient acuity have been converted to match the Victorian definitions to enable comparison.

**Queensland**

The qualifications required for NEPT staff to work for the Queensland Ambulance Service (QAS) are set by QAS

**South Australia**

Waiting on a response from SA

**Western Australia**

Western Australia require NEPT vehicles to be crewed with a minimum of patient transport officers with a Certificate III Pre Hospital Care (NSW) or Certificate III in Non-Emergency Patient Transport. Note: This is the minimum requirement for low acuity transport in Victoria.

**Tasmania**

**Low Acuity Only**

Patient transport officers with a Certificate III in non-emergency client transport or a Volunteer with a level 2 first aid Certificate is mandatory

## 6.4 Identification of options

The base case and three regulatory options are described below in Table 6.1.

The options analysed are an outcome based approach (Option A), a continuation of the current approach, (Option B), and industry based voluntary guidelines (Option C).

#### Table 6.1 Regulatory options

|  |
| --- |
| Option A – The Proposed Regulations – an outcome based requirement |
| The licence holder must ensure that each NEPT vehicle is crewed by staff with suitable skills, knowledge/competence and qualifications to ensure each patient’s medical needs can be met for the duration of the transport.If an NEPT crew is of the opinion that they do not have the necessary skills, knowledge/competence and qualifications, or their vehicle does not have the necessary equipment to ensure the patient’s medical needs can be met during the transport they may seek further clinical advice. A NEPT licencee must have arrangements in place to allow NEPT crews to seek further clinical advice. Every call from an NEPT crew seeking further clinical advice must be recorded and that record must be kept for 7 years. An exception to this requirement will apply where it is in the best interests of a patient to commence a journey with the nominated crew. For low acuity patients, visual observation must be maintained at all times during transport. For medium and high acuity patients a suitably competent and qualified crew member must travel in the patient compartment with the patient at all times. |
| Option B: The Current Regulations – a prescriptive requirement |
| The licencee must ensure that each NEPT crew member has a prescribed qualification and is professionally competent through education or experience to provide patient care for the duration of the patient transport.The licences must ensure that the NEPT vehicle crew is in accordance with the prescribed requirements.The qualifications that are prescribed are:Patient Transport Officer - Certificate III in Non-Emergency Patient TransportAmbulance Transport Attendant - Diploma of Paramedical ScienceAmbulance Officer – Degree of Paramedical ScienceClinical Instructor - Certificate IV Training and AssessmentThe required staffing of NEPT vehicles are as follows:Low Acuity patients1 patient transport officer or 2 patient transport officers depending on patient needsMedium Acuity Patients1 patient transport officer1 ambulance transport attendantHigh Acuity patients1 patient transport officer1 ambulance transport attendant, and 1 nurse or registered medical practitioner or1 patient transport officer1 nurse with critical care qualifications and experience in intensive care, or 1 member of staff from the PIPER neonatal or paediatric service. |
| Option C: Industry Based Voluntary Guidelines |
| Develop voluntary guidelines for the industry to adopt. Ambulance Victoria, public hospitals and most private hospitals would only contract with private NEPT providers that operated to the voluntary Code of Practice (the Code). The Code would set out what level of qualifications was required for what activity. |

Options A & B require that a licencee ensure that:

• staff that are competent to manage the needs of the patient during transport, and

• There is a sufficient number of suitably qualified and competent staff crewing each vehicle.

Option C is voluntary and relies on the desire of the licencee to operate to the Code.

## 6.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 5.2 below.

#### Table 6.2 Multi-criteria analysis criteria and weightings

|  |  |
| --- | --- |
| Criterion | Weighting |
| Protecting the service users through effective levels of safety and quality  | 50% |
| Cost | 50% |

### The base case

The base case in this section is taken as a scenario where the private NEPT providers are licenced to operate but have no regulations of obligations linked to operations.

Under the base case, private NEPT providers would not be subject to any Regulations and therefore could determine the crew mix and qualifications themselves. However some providers that have contracts with AV or hospitals may still be required to demonstrate to those organisations that their staffing arrangements are suitable.

In the absence of Regulations, it is reasonable to expect that ‘business as usual’ would still see the majority of proprietors employ sufficient, qualified staff, with the required skill mix. This can be expected due to:

* contemporary clinical governance arrangements
* contractual obligations which require the safe transport of patients
* regulation of registered health practitioners
* Reputation of NEPT licencees
* to a lesser extent guidelines and policy issues by professional colleges.

The base case would create the potential for a proportion of private NEPT providers to put in place a lower level of staffing than may be expected by the department or the community. In such a scenario crew numbers and capability would vary between providers. There would be potential for patients to be allocated crews who were not competent to manage their clinical needs, potentially leading to detrimental patient outcomes.

Based on engagement and interaction with the sector the department estimates the base case equal to:

* 90 per cent of licencees employing staff who are professionally competent with suitable qualifications and skill mix to provide patient care, having regard to the kind of health service being provided; therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations
* similarly, 90 per cent of licencees employing sufficient staff, to ensure patient safety; therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations

These assumptions have been informed by the department’s discussions with licencee proprietors and staff, as well as data and information collected during inspections. Compliance rates with current staffing ratios and skill mix is generally high. One of the reasons for that is that the current educational courses for training higher qualified NEPT officers have increased to degree level which is in excess of the current regulatory requirement.

The major area of noncompliance for staffing involves accepting patients for transport of a higher acuity than the crew are qualified to manage. Although 90 per cent compliance could be considered high, the risk posed by the noncompliant 10 per cent is considered significant. This element has been scored at 0 as it is the base case and is the point of relativity for options A & B.

There are costs associated with not having suitably qualified and competent NEPT crews transporting patients. Some adverse patient outcomes would be expected if the base case applied.

A 10% rate of unsuitable staffing for the 150,000 low and medium acuity non AV patient transports per year has been assumed for the purpose of this RIS, as explained above. In this scenario a second vehicle may need to be sent with a suitable crew. In the absence of data a 50% resend rate is assumed. Advice from the sector is the average cost of a medium or high acuity vehicle transport is $200.

A resulting adverse patient outcome rate of 2% is assumed (for the reasons described in section 5.5) at a cost of $8,960 per adverse overall. Therefore the overall cost of the base case is:

5% x 150,000 x $200 + 5% X 150,000 x 2% x $8,960 = $2,844,000 per annum.

### Option A: the proposed Regulations

The purpose of NEPT is to ensure the patient can receive the necessary care and monitoring in a safe manner during the transport.

Option A provides for increased flexibility for licencees for crewing of the NEPT vehicles while requiring that the staff must be suitably qualified, competent and skilled to meet the needs of the patients for the duration of the transport. This is an outcome based approach that addresses patient needs while providing flexibility for the licencee on the crew mix they can utilise for their fleet. For example a licencee may opt to run some vehicles specifically for low acuity rather than having a higher crew level in case they are sent to higher acuity patients.

Every vehicle will be required to have sufficient crew members who are suitably qualified and skilled to attend to the clinical needs of the patient who is being treated or transported. It will be for the licencees to determine which medically qualified crew members are allocated to the transports. For medium and high acuity patients the person who is providing the clinical monitoring and/or medical supervision will be required to travel in the compartment with the patient to ensure immediate care is provided should it be required. For low acuity patients the licencee will be required to demonstrate how the patient will be actively clinically monitored during transport.

The regulations will require that any person attending to a patient during treatment or transport must have suitable qualifications and skills to enable them to safely provide the required clinical care to the patient. The cost of staff acquiring the necessary competencies has not been costed as it is assumed that the employee will be required to have attained the necessary competencies in order to be employed. Therefore the cost is not imposed on the NEPT licencee by the Regulations.

The Regulations will not prescribe what qualifications a person must hold to treat the acuity of the patient. This will be the responsibility of the licencee to determine. The flexibility provided by this approach will allow the licencees to optimise vehicle and staff deployment by matching vehicles and crews to the needs of the patients. It will also allow for the use of vehicles dedicated for specific patient acuities should that be desired by the licencee.

The protection of patients in Option A through prescribing the competency requirements has been scored at +8 as it provides for patient safety and clinical care to a high degree.

The further requirement to have an accredited quality assurance plan (described in Chapter 7) will impose a requirement on the licencee to document how they will ensure staff competence and qualifications are suitable and what ongoing training will be provided to ensure competence is maintained.

In calculating the incremental costs the following data and estimations were used:

* Estimated that under the base case 90 per cent of proprietors are employing staff who are professionally competent. Therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations.
* Estimated that under the base case 90 per cent of proprietors are employing sufficient numbers of NEPT staff on duty. Therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations.
* There are 20 licenced private NEPT providers, with a total of 339 vehicles and 5 aircraft that undertake an estimated 350,000 transports per year.
* The total NEPT workforce crewing vehicles is estimated at 688.
* NEPT crews usually operate one shift per day, however overtime may occur.
* According to data provided by the sector the highest salary for any crew member (a registered nurse) is $1230 per week. Factoring in an average 41 hours per week, and using the 1.75 multiplier for on-costs and overhead costs, this equates to an hourly rate of $62.05 – see appendix A 4.

NB: Overtime is not included in the calculations.

Incremental costs of employing sufficient numbers of NEPT staff with sufficient skill mix and qualifications:

* ‘Sufficient’ is defined as using enough crew members to meet the clinical needs of the patient during transport. The average crew numbers have been calculated at 2 crew members per vehicle although it is noted that some low acuity transports will only require 1 crew member and some high acuity transports will require 3 crew members.
* Skill mix is not prescribed but is required through an outcome based regulation that requires all staff transporting patients to have the necessary competence, qualifications and skills to manage the clinical needs of the patient being transported.
* Because it is estimated that 90 per cent of proprietors would meet this requirement under the base case, the incremental cost calculating the cost attributable to the 10 per cent who would need further staffing or improved qualifications of staff under the Regulations.

#### Incremental cost of the Regulations:

344 vehicles, assuming full use for 1 shift daily, 5 days per week.

100% compliance @ 2 staff per vehicle = 688 staff.

90% compliance @ 2 staff per vehicle = 619 staff.

Assuming the remaining 10% operating with 1 crew member = 35 staff.

Total staff (619+35) = 654 staff.

Incremental cost would be the cost of the additional 35 staff.

35 × $2,544 x 44 = $3,917,760 per annum.

Incremental cost of Regulations = $45,008,010 (10 year discounted cost) – see Appendix A 4 for the calculations.

The cost of Option A has been scored at -1 as it is a relatively higher cost over the life of the regulations than the base case.

#### Table 6.3 Incremental costs attributable to proposed Regulations

|  |  |  |
| --- | --- | --- |
| Requirement | Annual cost $ | Average cost $ equal to |
| Ensure that each NEPT crew member is professionally competent through education and experience to provide patient care for duration of the patient transport and that whenever patients are being transported a sufficient number of appropriately educated and experienced NEPT crew is on duty to provide care. | 3,917,760 | 111,936 per additional staff member required |

#### Cost of the Regulations

Employing suitable staff with the necessary competencies would remove the adverse events that would arise from not doing so and remove and the need for a second vehicle to be sent as in the base case. The cost of option A when compared with the base case is $1,073,760 per annum.

#### Table 6.4 Multi-criteria analysis – the proposed regulations

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Protecting the service users through effective levels of safety and quality | 50% | +8 | +4 |
| Cost | 50% | -1  | -0.5 |
| **TOTAL** | **100%** |  | **+3.5**  |

#### Net Cost of the Regulations

The net cost of the regulation is$2,844,000 - $3,917,760 = $1,073,760 net cost p.a.

The net 10 year incremental cost is $12,263,722

### Option B: the alternative regulatory option

The alternative regulatory option is the continuation of the current Regulations albeit updated to provide for new qualifications, tied to the acuity of the patient, that have replaced the exiting mandated qualifications.

The staffing requirements are linked to the patient acuity to enable the licencee to provide a crew with qualifications commensurate with the patient’s clinical needs. However as the vehicles used for unplanned transports must be able to cope with all patient acuities in practice these vehicles may be crewed with more highly qualified staff to allow it to attend a range of patient acuity call outs.

The crewing requirements described in Option B are the minimum levels of staffing required.

The Regulations will require that the person attending to any patient during treatment or transport must have the prescribed qualifications to enable them to safely provide clinical care to the patient.

The Regulations will prescribe qualifications a person must hold to treat the acuity of the patient. This will require the licencee to default to the highest qualification linked to acuity rather than determining what qualifications and competences best meet the needs of each patient.

There is a risk with option B that a prescribed qualification may cease to offered by the education sector for a range of reasons. For example, a higher level qualification may be introduced, or education institutions may cancel the course due to insufficient enrolments, etc., as has occurred with the current Regulations.

The experience with the current regulations is that once the courses offered by the educational institutions changed it was not possible for the regulations to be complied with, albeit the staff were educated to superior qualifications.

A significant difference with Option A is that there is no requirement for the staff to be competent to meet the clinical needs of the patient. The current regulations have assumed this is the case if a staff member has the necessary qualifications and has undertaken the 400 hours of clinical practice. Potentially this creates a risk differential to Option A and therefore Option B has been scored at +6.

Costing is the same as for option A and is scored the same.

#### Table 6.5 Multi-criteria analysis – the alternative regulatory option

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Protecting the service users through effective levels of safety and quality | 50% | +6 | +3 |
| Cost | 50% | -1 | -0.5 |
| **TOTAL** | **100%** |  | **+2.5**  |

### Option C: a voluntary Code of Practice

Option C provides for a voluntary Code of Practice (the Code) to be developed by the NEPT sector to provide guidance on suitable staffing for NEPT vehicles. The Code would set out what staffing qualifications and numbers were required for the various types of patients and the NEPT licencees would choose whether or not to adopt the Code.

Ambulance Victoria, public hospitals, and private hospitals would be strongly encouraged by the department to only contract with NEPT licencees who had adopted the Code. However those NEPT licencees who did not wish to contract to AV or hospitals would have no market incentive to adopt the Code. It would therefore be their decision to so or not. It is estimated that at least 7 licencees would be in this situation, mostly those whose prime business is stand-by services at public events.

Two issues arise with this approach. Firstly there is no NEPT industry peak body and therefore no organisation to take overall responsibility for the development and updating of the Code. Secondly the Department would be unable to ensure that all patients were receiving appropriate clinical care during their journeys as it would not have responsibility for setting or monitoring staffing arrangements. So for patients Option C is a potentially riskier alternative than either of the other two options. Therefore the protection of the patients has been scored at 0.

Note: The Department would have the option of placing a condition on the licences of NEPT providers to require compliance with the Code. Such an approach would not be preferred as the Department would be effectively mandating a Code over which they had no control or authority. It is not usual to for Government to mandate such documents through conditions on licence.

The use of the Code would mean that the Regulations would not be imposing a cost on the NEPT sector in relation to staffing requirements. All staffing decisions would be for the licencee whether or not they adopted the Code. In turn this creates a similar position as the base case in that there is no regulatory compulsion for vehicles to be staffed appropriately and therefore the cost is the same. As a result Option C is scored at 0 for the MCA.

The overall MCA score is 0.

#### Table 6.6 Multi-criteria analysis – voluntary Code of Practice

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Protecting the service users through effective levels of safety and quality | 50% | 0 | 0 |
| Cost | 50% | 0  | 0  |
| **TOTAL** | **100%** |  | **0**  |

## 6.6 The preferred approach

Based on this analysis, the department considers that Option A, the proposed Regulations, is preferable to the alternative options assessed, as shown in Table 6.7.

#### Table 6.7 Summary of MCA scores for options

|  |  |
| --- | --- |
| Option | MCA score |
| Option A: the proposed Regulations- an outcome based requirement | +3.5  |
| Option B: the alternative regulatory option – a prescriptive requirement | +2.5  |
| Option C: a voluntary Code of Practice | 0 |

#### Option A is the preferred option.

# 7 Quality Accreditation

## 7.1 The nature and extent of the problem to be addressed

Sections 15 and 22 of the Act sets out the matters the Secretary must consider in deciding whether or not to grant a licence. Section 15(2)(a) requires the Secretary to consider:

1. The suitability of the equipment and vehicles to be used in the service; and
2. Whether or not there are operating arrangements for the management and staff of the service are suitable and comply with the Regulations; and
3. Whether or not there are arrangements for maintaining the quality of the service are appropriate; and
4. Whether or not there are arrangements for evaluating, monitoring and improving the quality of the service that are appropriate.

Section 22(2) requires the Secretary to consider:

 b The quality of the services operated under the licence is satisfactory; and

 c The service operated under the licence complies with this Act, the regulations and any other law

 relating to or affecting the operation on a non-emergency patient transport service; and

 d The conditions to which the licence is subject have been complied with.

The requirement for a licenced NEPT business to have an accredited quality assurance plan with prescribed components enables the Secretary to meet these obligations by reviewing the Plan and verifying the plan is accredited.

There currently is no standardised quality framework that the industry uses. Therefore the proposed Regulations set out the minimum matters that must be included in the Quality Assurance Plan and that must be monitored both by the NEPT service and by quality accreditation assessors.

The onus to comply is placed on the licencees. That is the licencees must include the minimum matters prescribed in the Regulations in their quality assurance plan. For initial accreditation and subsequent accreditation renewals the accreditation assessors will review compliance by the NEPT licencee with all elements of the Plan and whether the documentation included in the Plan is adequate, as part of their standard operating procedure required under their JAS-ANZ or ISQua accreditation. Should the accreditation agency not assess all elements of the Plan the remedy is for the Department to lodge a complaint with JAS-ANZ or ISQua.

The licence application process will also require any applicant for a new licence to provide the Department with a gap analysis of the Quality Assurance Plan if it is yet to be accredited at the time the licence is applied for. This is a new requirement and will result in an additional cost. As the regulations will provide a 3 month period for a new NEPT licencee to obtain accreditation the gap analysis will allow the Department to review progress towards accreditation prior to issuing a licence and determine if it will be feasible for the applicant to achieve accreditation within the 3 months. If the Department forms a view that it would not be feasible to achieve accreditation within the mandated time it may delay the issuing of the licence until it is satisfied that the deadline can be met. Over the life of the Regulations there has been an average of one new licence application per year.

NB: the 3 month period to achieve accreditation is consistent with the requirements placed on private hospitals and day procedure centres (to whom the NEPT licencees provide a service).

There was widespread consensus during the consultation process among licencees, about the need for all NEPT providers to have a quality management system in place to ensure a suitable standard of patient care and the related administrative processes are achieved at all times.

Organisations with a culture of patient centred care view the accreditation process as adding value to their business by assisting with ensuring quality patient care and embedding continuous improvement. Lesser performing businesses, across all industry sectors, typically view quality assurance accreditation as a burden to be met with the minimum of effort and cost.

Since 1 July 2000, all Victorian public hospitals have been required to be accredited. Since 2013 all public hospitals, private hospitals and day procedure centres have been transitioning to accreditation to the National Safety and Quality Health Service Standards. All facilities are required to be accredited by 2016. The NEPT contractors have a significant interface with hospital operations and it is considered important that patients who are transported are afforded a similar level of service quality assurance as within the hospital system.

NEPT licencees have been required to be accredited since the introduction of the current Regulations in 2005.

The health care environment is one of increasing complexity, unparalleled technological change and heavy service demands. Assuming and stating that a health care service gives safe, quality care is not enough to meet legal, ethical and public demands and expectations. Consumers want assurance that their care is safe and appropriate and health care professionals want assurance that governments and health service governing bodies do more than pay lip service to safety and quality. The rise of healthcare related litigation reflects consumers’ determination to enact their right to demand the highest level of care.

Almost all patient adverse events result from deficient systems of care or unavoidable clinical reactions to treatment.[[21]](#footnote-21) Berwick, as quoted in the Healthcare Leadership & Management Report, contends that ‘our health care systems are perfectly designed to get the results they get.”[[22]](#footnote-22) In other words, if we fail to improve our systems, we will fail to adequately monitor and manage risk and improve service outcomes. One way of addressing this has been through accreditation processes.

An accreditation system will assist NEPT organisations to ensure that the necessary internal structures and systems are in place to identify, monitor, report and respond to risks and important aspects of care and provide for continuous improvement in their operation. Organisations that have achieved certification communicate to the market that they have successfully undergone a comprehensive, rigorous assessment and their process and organization meet defined standards of quality.

A well-functioning quality assurance system that is independently reviewed and accredited reduces the need for prescriptive regulation which is by necessity a “one size fits all” approach, and it creates an environment where a risk based approach can be utilised by the regulator, thus reducing the regulatory impost on good performers through reduced inspections.

A quality assurance plan is a continuous improvement model that is tailored to the specific business. The business is required to document its processes and procedures and to identify all safety and quality risks. The plan documents how those risks will be managed and what will happen in the event a risk is not managed. Every time something goes wrong the process and procedures are reviewed and, if necessary, updated to prevent the issue from recurring. In this way continuous improvement is achieved.

By prescribing minimum elements that must be included in the Plan we can be assured that the accreditation process will be reviewing matters that are necessary to ensure patient safety and care.

The Department will also review the prescribed elements of the quality assurance plan with every application for a licence or renewal of a licence to ensure it is satisfied the requirements of the Regulations overall are being met.

## 7.2 Objectives

The objective of the Regulation is to ensure that the accredited quality assurance plan manages the matters that can impact on patient safety appropriately.

A secondary objective is that the licenced NEPT provided will use the Quality Assurance System as a continuous improvement driver for the business in relation to patient care and safety thus leading to improved patient care over time.

## 7.3 Interstate arrangements

No other jurisdiction in Australia mandates that NEPT services must operate to an accredited quality assurance plan.

## 7.4 Identification of options

The base case of no regulations would mean there would be no requirement for a licencee to obtain accreditation of their quality assurance plan nor even have a quality assurance plan.

Option A requires a large number of elements to be incorporated into the quality assurance plan. This approach is adopted, rather than prescribing each outcome in regulation, as it is recognised that there are significant differences in the way some of the NEPT businesses operate. For example some businesses specialise in long distance rural transport, some in metropolitan transport, some in high acuity transport, some as stand-by service providers at public events. Some providers do not transport any patients but only operate as first aid providers at public events.

Option B continues with the current approach which is to require accreditation of the quality assurance plan but not specify any of its contents. Option B would allow new licencees to operate for up to 18 months without accreditation as currently.

Apart from the options of the base case (no accreditation), option A (mandate accreditation and prescribe minimum elements of the Quality Assurance Plan) or option B ((mandate accreditation and not prescribe any contents of the Quality Assurance Plan) no other workable options have been identified. Voluntary accreditation was considered but in practice would be the same as the base case as NEPT licencees could opt to obtain accreditation in the absence of a regulatory requirement.

## 7.5 Assessing the options

The cost of using an accreditation service varies, with the average annual cost for small companies (less than 12 full time equivalent positions) being approximately $2,000 (1 surveyor for one day).

The cost of preparing for and maintaining accreditation would vary as a function of the company size, complexity of the business, and the nature of existing quality processes already in place. However, estimates obtained by the department from small NEPT licencees suggest that this would be in the order of a $7,500 establishment cost for a small company to do the paperwork required for accreditation and to introduce staff to the system. The recurrent cost would be in the order of $2,500 per annum.

Existing NEPT providers have been accredited since the introduction of the 2005 Regulations. Therefore, mandating the use of an accreditation process would have no additional impact on these organisations. It is likely that prescribing the minimum elements to be included in the quality assurance plan will create a one off costs for a small number of providers who do not already include these elements in their current quality assurance plan.

For the MCA the first criterion of managing patient safety risks is the objective and is weighted at 50% with the costs of the requirement also being weighted at 50%

####  Table 7.1 Multi Criteria Analysis criteria

|  |  |
| --- | --- |
| Criterion | Weighting |
| Ensure patient safety risks are managed through the accreditation of quality assurance plans | 50% |
| Cost | 50% |

### The base case

The base case of no regulations would mean a licencee would not be required to have quality assurance plan accreditation. However many licencees would still operate to an accredited quality assurance plan as a cost of doing business as it would be a contractual requirement of AV, of public and private hospitals, and of other customers.

Six of the larger licenced NEPT businesses are contracted to AV to provide NEPT transport. As part of the contractual arrangements AV requires the businesses to be operating to an accredited quality assurance plan. In addition there are a number of licenced NEPT businesses who are contracted directly by public and private hospitals and other organisations. A number of these contracts also require the NEPT licencees to operate an accredited quality assurance plan.

It is estimated that 7 licencees would not have to implement an accredited quality assurance plan if it was not a requirement of the regulations. These are licencees that provide stand-by services and not patient transport. All other licencees are believed to have accredited QA plans part of their contractual arrangements with clients.

Without a quality assurance plan and regulations there would not be assurance that all NEPT providers would adequately manage patient safety risks. No cost is associated with the base case.

### Option A: the proposed regulations

The proposed regulations are intended to ensure all licencees have in place suitable processes and procedures to manage patient safety risks and patient care appropriately. There will be a cost to obtain and maintain accreditation of the quality assurance program however for a large number of licences this is a cost of doing business irrespective of any regulatory requirement. As explained in the base case it is estimated that 7 licencees will be most affected by the regulation. This is because the majority of licenced NEPT businesses have contracts with AV, hospitals, or other organisations, which require accreditation of quality assurance plans.

Further as the Regulations will now prescribe minimum elements to be included in the QA plan it is estimated a further 3 licencees will be required to upgrade their plans. These are licencees who transport NEPT patients but who may not have a sophisticated quality assurance plan as they are not contracted to AV or large hospitals.

Mandating minimum elements to be included in the quality assurance plan will provide flexibility. It will allow the businesses to tailor and document their own policies, processes, record keeping, staff training, etc. to meet their particular business needs.

The time limit from initial registration to obtaining accreditation is to be reduced from the current 18 months to 3 months. As part of the application for registration any new applicant will be required to provide the department with a gap analysis of their quality assurance plan so the department can assess whether it is feasible for accreditation to be achieved within the 3 month time limit. This will impose a cost on the new applicant.

Costs associated with obtaining accreditation are:

* Preparation of the QA plan
* Maintenance of the QA plan
* Annual accreditation of the QA plan

Annual audit cost is $2,000

Annual Certification Cost is $1600

Initial QA plan preparation is $7,500

QA plan maintenance is $2,500

The cost of developing a QA plan and obtaining accreditation is estimated at $7,500 + $3600 = **$11,100**

The cost of maintaining a QA plan and obtaining accreditation is estimated at $2,500 + $3600 = **$6,100**

Therefore the costs to achieve initial accreditation are $11,100 + 8 (7 existing and one new licencee) x $6,100 = **$59,900 p.a.**

It is also likely that the licencees who are not contracted by AV or hospitals will need to upgrade their Quality Assurance Plan to meet the prescribed requirements. There would be an additional three licencees affected in this way and these would be likely to be larger operators with more complex businesses.

It is estimated it would take one full time weeks work for these businesses to upgrade the plans to a suitable standard to be accredited under the new regulation.

Therefore 3 (licencees) x 38 hours x $62.05 = **$7,074**

New licencees will be required to achieve accreditation within 3 months of initial licencing which is consistent with the requirements applied to the registration of private hospitals. Arguably the QA plans of NEPT providers are simpler than those of private hospitals. A maximum of 3 months to obtain accreditation will apply a degree of rigour and risk management to the licencing process that is lacking at the moment. This requirement is expected to affect one applicant annually.

Further the regulations will now require the submission of a gap analysis of the draft QA plan to be submitted with any application for initial licencing. There will be a cost associated with this requirement that again is expected to affect one applicant annually. This cost is estimated at $3000 – see appendix C.

The total cost of the requirement therefore is:

$59,900 + $7074 + $3,000 = **$69,974**

The 10 year discounted cost is $805,645. See appendix A 5 table A 5.1

As accreditation will allow the Department to move to a risk based approach there is potential for savings for the sector as they will no longer be subject to routine inspections that duplicate the accreditation assessment. Instead the Department will use a range on inputs to assess the relative risks of the licences and target the visits to licencees and, or matters of identified risk. It is anticipated that there should be saving to the sector as a result. However it is not possible to estimate any potential savings as it is not yet known with what frequency visits to licencees will occur.

In addition accreditation will result in continuous improvement in the management of patient safety over the life of the Regulations. Every time a there is an occurrence of a situation the results in compromised patient safety the issue will be reviewed and the quality assurance plan will be upgraded to prevent a recurrence. Over the life of the Regulation this will lead to savings due to improved patient care. However as there is no data or readily available proxy it is not possible to estimate the degree or quantum of reduction in patient safety risks across the sector and therefore any savings attributable to this element have not been costed

The prescribed elements for inclusion in the quality assurance plan and the accreditation of the Plan are central to the management of patient safety risks by the sector. Therefore thus element has been scored at the maximum as any other option requiring accreditation would have a lesser effect in managing patient safety risks.

Costs will only be incurred by 7 licencees as a result of the regulation and the overall costs to the sector are not large. Therefore the costs have been scored at -2.

NB: The value of a statistical life year is $182,170. Therefore should the accreditation result in one life being saved per year and that person living a further 10 years, as is reasonable to assume, then the saving would approximately equal the cost of the regulation. However as there is no data on which to base any such assumption no potential savings have been included in the cost analysis.

#### Table 7.2 MCA scores for the proposed regulations

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Ensure patient safety risks are managed through the accreditation of quality assurance plans | 50% | +10 | +5 |
| Cost | 50% | -2 | -1 |
| **TOTAL** | **100%** |  | **+4** |

### Option B: the alternative regulatory option

The alternative regulatory proposal is a continuation of the current regulation which requires licenced NEPT businesses to be accredited but without placing any requirements around what elements should be included in the QA plan. Further the current regulation allows a period of 18 months to achieve initial accreditation after licencing.

The department could not be sure that all quality assurance plans would suitably manage all patient risks and therefore would either result in a lower level of patient risk management or alternatively require the enactment of additional minimum regulations as a safety net, potentially over regulating certain licencees with the accompanying cost impacts. It would also require the department to continue with routine inspections to ensure it could monitor the management of the regulated patient safety risks.

It is anticipated each licencee would need a minimum of an inspection every year in order for the Department to satisfy itself that patient safety and care was being managed appropriately. The costs of Option B are calculated below. They comprise some of the same costs as option 1 as accreditation is still required plus additional costs relating to the inspections of all services.

Costs associated with obtaining accreditation are:

* Preparation of the QA plan
* Maintenance of the QA plan
* Annual accreditation of the QA plan

Annual audit cost is $2,000

Annual Certification Cost is $1600

Initial QA plan preparation is $7,500

QA plan maintenance is $2,500

The cost of developing a QA plan and obtaining accreditation is estimated at $7,500 + 3600 = **$11,100**

The cost of maintaining a QA plan and obtaining accreditation is estimated at $2,500 + 3600 = **$6,100**

Therefore 8 (7 existing and one new licencee) = $11,100 + 8 x $6,100 = **$59,900 p.a.**

20 licencees X 1 inspection per annum X 6 hours (at $ 95.86 per hours) = **$11,503**

+ cost of current accreditation (same as for proposed option)

= $11,503 + $59,900

= **$71,403 p.a.**

These costs are comparable to option A and have been scored the same at -2

Option B which would require accreditation to manage patient safety risks without specifying minimum inclusions will result in a lesser patient risk management framework as it could not be assumed all licences would include all the patient safety elements in their QA plan. Therefore this element has been scored at +5 as option B potentially poses a relative increased risk to patients.

#### Table 7.3 MCA scores for the alternative regulatory proposal

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Ensure patient safety risks are managed through the accreditation of quality assurance plans | 50% | +5 | +2.5 |
| Cost | 50% | -2 | -1 |
| **TOTAL** | **100%** |  | **+1.5** |

## 7.6 The preferred approach

Based on this analysis, the department considers that Option A, the proposed Regulations, is preferable to the alternative option assessed, as shown in Table 7.4

**Table 7.4 Summary of MCA scores for options**

|  |  |
| --- | --- |
| Option | MCA score |
| Option A – prescribed minimum requirements in the accredited quality assurance plan | +4 |
| Option B – no prescribed minimum requirements in the accredited quality assurance plan | +1.5 |

Option A, minimum requirements in the accredited quality assurance plan is the preferred option.

# 8 Other Regulations

## 8.1 The nature and extent of the problem to be addressed

The analysis in this RIS has focused on those Regulations that result in an incremental cost to private NEPT licencees. There are a number of proposed Regulations that have not been analysed for alternative options. The reasons why they have not been considered for further analysis include:

* the regulation gives practical effect to the Act
* the cost of the requirement is more accurately attributed to the Act
* the cost of the regulation or requirement is of low impact to the sector because it represents ‘business as usual’
* the cost of the requirement is more accurately attributed to other frameworks

This section details these Regulations and provides a rationale for their inclusion and seeks to quantify the cost (if any).

## 8.2 Regulations that give practical effect to the Act

Regulations 4, 5, 7, 9, & 11 are definitions that are required to provide scope and give effect to the Act. Defining classes of service and the levels of patient acuity underpin the staffing requirements that are costed earlier in this RIS.

Regulations 22-29 prescribe the various forms of application which can be made under the Act and the fees payable to the department. The fees component is discussed in Section 4. The forms are currently one-page documents that include a number of fields for the provision of contact details and basic information. It is not possible to streamline these forms further. While some of the forms require further documentation to be attached, this is in accordance with the criteria detailed in the Act, not the Regulations.

Regulation 36 requires a provider of aeromedical services to provide a copy of the CASA certification with any application for a licence or renewal of a licence.

## 8.3 Regulations with cost attributed to the Act

Nil

## 8.4 Low-impact regulations

The base case in this section is taken as a scenario where the private NEPT providers are licenced to operate but have no regulations or obligations linked to operations.

The following Regulations have not been included for analysis of this RIS because they represent ‘business as usual’ for the administration and management of private NEPT businesses.

Regulations 7, 9 & 11 define low, medium and high acuity patients. These definitions are linked to Regulation 17 that requires that any vehicle used to transport patients must have the skill, competence, knowledge and qualifications appropriate for ensuring the patients’ clinical needs can be met during the transport. The intent of these regulations taken as a whole is to ensure patients are safely transported whatever their condition provided it is not an emergency.

The definitions prescribe what the medical conditions are that determine the acuity of a patient. The definitions are consistent with current clinical practice and are the result of expert clinical advice. The definitions provide guidance in determining what crew skills and knowledge and vehicle equipment are required to transport the patient safely. However the patient acuity definitions are not linked to specific staff qualifications or specific vehicle equipment requirements and therefore do not directly impose costs on the sector. It is the decision of the NEPT provider to determine what crews and vehicles are required for which patients once they have been notified of the patient acuity and condition.

Regulation 21 requires staff crewing vehicles to wear an identification tag that lists their name and position, and the trading name of their employer.

Regulation 31 requires the NEPT licencee to provide the Secretary with an annual report. If we allow a $500 cost per licencee to provide the annual report (5-6 hours preparation which is probably overstating the time required) the cost to the sector is $500 x 20 licencees = $10,000 per annum. This cost is considered to be of low impact.

Regulations 34 – 36 requires the NEPT provider to keep certain patient care records and staff records.

Regulation 34 is the requirement to keep the records. Regulation 35 prescribes the patient care records to be kept. Regulation 36 prescribes the staff records to be kept.

The patient care records identify the patient, why they are being transported, their clinical condition, who is transporting them, and their pick up and destination. The staff records identify the staff, and list their vaccination status and skills maintenance.

Both the requirements are considered “business as usual”. The records would be required to be kept by the majority of NEPT providers as part of working for AV or working for hospitals. The use of clinical patient records and files is part of core business in health care.

Maintaining clinical records is also a feature of health care professions’ codes of conduct and practice guidelines. For example, Good Medical Practice: A Code of Conduct for Doctors in Australia, states that ‘maintaining clear and accurate medical records is essential for the continuing good care of patients’.[[23]](#footnote-23)

Some staff records are routinely kept for tax reasons. The additional information on staff vaccination history and skills maintenance is essential information due to the potential for impacts on patients. It goes to managing business risk and would be considered good business practice whether or not there was a regulation to require it.

Regulations 38 & 39 require NEPT licencees to establish a complaints register to record complaints made by, or on behalf of patients. They prescribe the details to be recorded. The information is necessary to allow the licenced NEPT provider to conduct a “look back” should they receive a complaint and to allow the department to undertake an investigation should it be necessary. There have been very few complaints received over the life of the 2005 Regulations and therefore it is considered that this requirement is low impact.

Regulations 40-42 require an NEPT licencee to provide its contact details to patients prior to transport and to provide patients with an information brochure, containing specified information about their rights, on request. Advice from the NEPT sector is that few patients request the brochure and as a result the costs associated with its provision are minimal.

Regulation 44 requires all NEPT vehicles to carry warning lights for deployment at any incident the vehicle may attend. The majority of NEPT vehicles carry such lights. Mostly these are vehicles contracted to AV who carry red and blue emergency lights in case they are required to transport an emergency patient.

NEPT vehicles may be required to secure a road accident scene by being placed across the road. In these situations it is necessary for the safety of all at the accident scene for the vehicle to be able to warn oncoming traffic of the danger.

The Regulation will not specify the type of warning light that must be carried. A portable amber light would suffice. There would be a one off cost of about $150 per vehicle for the vehicles that are not already equipped. If we assume 50% of vehicles would need a light (probably an overestimate) the sector cost would be $22,500. Therefore it is considered the cost of this requirement is low impact.

Regulation 45 requires that all vehicles and equipment must be kept in a good working condition at all times patients are being transported. This is not considered to impose an additional cost as it is a cost of doing business both in terms of transporting patients’ safely and is required for Vic Roads and occupational health and safety reasons.

Regulation 48 requires all NEPT vehicles carry a defibrillator, oxygen, resuscitation equipment and suction. Advice from the NEPT sector and AV is that this is the minimum equipment that all vehicles should carry in order to transport any patient to enable them to deal with unexpected patient deterioration. It is also a requirement of contracts with AV (which cover the 6 largest NEPT providers). As a result the requirement may impose a cost on the 13 NEPT licencees that operate less than 10 vehicles. Therefore the cost to the sector is considered to be low impact. Most of the vehicles of smaller providers would carry some or all of this equipment as part of their normal business regardless of any regulatory requirement.

# 9 Impacts on competition

The analysis in this RIS has concluded that, based on the information available to the department, the proposed Regulations meet the objectives better than the base case and the assessed alternative approaches.

## 9.1 Groups affected

Groups affected by the proposed Regulations or their alternatives, include NEPT providers, their staff, patients, hospitals, and Ambulance Victoria.

## 9.2 Impact on small business

The Victorian Guide to Regulation provides a definitive guide to developing regulations in Victoria. In particular, it is important to examine the impact on small business, because the compliance burden of regulation often falls disproportionately on that sector of the economy.

Most of the current licenced NEPT providers are considered to be small businesses. Only 3 businesses operate more than 50 vehicles.

The majority of the measures contained in the proposed Regulations are scalable to the number and type of patients, and are therefore proportionate to business size. It is noted that some requirements are not based on business size, such as the need to have an accredited quality assurance plan and a complaints management process in place, which theoretically impose a disproportional cost on smaller establishments. However as these plans are written by each business, they reflect the business complexity and are tailored to their needs. Therefore there is a degree of scaling. As discussed previously, these types of requirements are also considered ‘business as usual’ in health care.

Given that the proposed Regulations are largely a continuation of the 2005 Regulations that have been in place for over 10 years, the department does not expect that the proposed Regulations will raise any implementation issues or cause unintended consequences for smaller health service establishments. However the change to the assessment of patient acuity is expected to deliver large savings to patients, and improve response times of emergency ambulances and as a result provide opportunity for some existing licencees to expand their business and potentially attract new entrants to the market.

Under the current regulatory approach, the department provides significant guidance and education to smaller establishments to support them to have required policies and procedures in place and this will continue.

## 9.3 Assessment of impact on competition

The guiding principle in assessing competition impacts is that Regulations should not restrict competition unless it can be demonstrated that the benefits of the restriction to the community as a whole outweighs the costs, and that the objectives of the Regulations can only be achieved by restricting competition. The National Competition Policy (NCP) ‘competition test’ was used to assess the proposed Regulations against any possible restrictions on competition. The test asks the following questions relating to the proposed Regulations:

* Is the proposed measure likely to affect the market structure of the affected sector(s)?
* Will it be more difficult for new firms or individuals to enter the industry after the imposition of the proposed measure?
* Will the costs/benefits associated with the proposed measure affect some firms or individuals substantially more than others (for example, small firms, part-time participants in occupations, etc.)?
* Will the proposed measure restrict the ability of businesses to choose the price, quality, range or location of their products?
* Will the proposed measure lead to higher ongoing costs for new entrants that existing firms do not have to meet?
* Is the ability or incentive to innovate or develop new products or services likely to be affected by the proposed measure?

Assessed against this test, the proposed Regulations impose restrictions on firms entering or exiting a market by requiring their registration. However, in this context, it is noted that the restrictions are imposed by the Act, with the proposed Regulations providing some detail to the regulatory requirements and giving practical effect to the Act. The cost of complying with the proposed Regulations is considered to be justified by the benefits achieved by the Regulations, and not materially greater than the costs associated with the base case.

The proposed Regulations are unlikely to make it more difficult for new proprietors to enter the market, because they represent minimum requirements for patient safety and in many instances mirror what is required in private contractual arrangements between hospitals and NEPT providers and AV and NEPT providers.

Taking into account the variation in the level of acuity of patient being transported and the consequent differences in the types of vehicles and staffing required, the proposed Regulations are not considered to create a relative competitive disadvantage or advantage.

The proposed Regulations apply equally to all businesses and consumers. Therefore, the proposed Regulations are considered to meet the NCP ‘competition test’ as set out in the Victorian Guide to Regulation.

## 9.4 Implementation and enforcement issues

The proposed Regulations are intended to commence by no later than 8 November 2016.

Under the proposed Regulations, the department will continue to be responsible for the regulation of all NEPT providers, and will undertake a range of monitoring and enforcement activities to ensure proprietors meet their obligations under the Act and Regulations.

The current scheme contains a range of enforcement measures, such as placing conditions on licences, revocation of licence or prosecution. In the current legislation, there are a number of prosecutable offences.

These measures offer a fair and proportionate range of compliance measures, which aim to educate proprietors and support them in making positive changes to their business and services offered to patients.

Senior nurse advisors of the department, as authorised officers, monitor and enforce compliance with the Act, the Regulations and conditions of licence, by:

* inspections of establishments: assessing policy, procedures and practices in clinical care, as part of the application for renewal of licence or pre-licence
* prompt and thorough complaint investigation involving site visits that may, depending on risk analysis, lead to a full site inspection
* requiring action plans from proprietors to rectify issues of noncompliance where identified and conduct follow-up inspections

The authorised officer role has a strong educative focus and enables the meaningful exchange of information between the department and licencees. Authorised officers can assist licencees to understand and implement changes to procedures, practices and documents to ensure compliance with the legislation. This occurs both during inspections and as part of their ongoing relationship with the sector. In addition, authorised officers provide education through specific projects to assist licencees in either complying with the legislation, or developing better practices.

If the Minister is satisfied that a licencee has failed to carry on the NEPT business in accordance with the Act, the Regulations or any condition of licence, the Minister may revoke the licence of the provider in accordance with the Act.

In all cases, the department works with proprietors to resolve any problems. Prosecution or revocation of licence is a measure of last resort.

## 9.5 Evaluation strategy

The Subordinate Legislation Act 1994 revokes statutory rules following 10 years of operation. This allows the government to examine whether there is still a problem that requires government intervention, and to take account of any changes or developments since the regulation was implemented. When regulations are remade, the government assesses whether the objectives of the regulation are being met, whether practical experience suggests ways in which they can be improved, or whether a different regulatory approach is warranted. Final development of the Regulations is informed by public input through the RIS process.

As noted in Section 9.4, the authorised officers will continue to visit registered health service establishments using a risk management approach. These inspections provide compliance data that is used by the department as a proxy for the safety and quality performance in these facilities.

In addition, the department intends to analyse non-conformance data from audits of NEPT licencees, complaint data, and reports of death or adverse events during transport. This will assist the department to assess whether there is a relationship between licencees that are systematically noncompliant with regulations requirements and a higher rate of adverse events. To date this data has not generally been collected.

# 10 Stakeholder consultation

From April to June 2015 the department undertook a number of targeted consultations by contacting key stakeholders, to discuss the review of the regulations to determine what should be included in the regulations. Ongoing consultations with some stakeholders have continued since then.

The majority of issues raised related to the content of the 2005 Regulations and the unnecessary impediments that they had introduced. The key themes from the feedback related to:

* that impediments created by requiring a medical practitioner to assess the acuity of medium and high acuity patients
* the restrictions placed on nurses that prevented them from operating to their scope of practice.
* the restrictions placed on the use of drugs to care for patients during transports
* concerns that the department was not enforcing the Regulations robustly enough

An overview of stakeholders’ views is provided below in section 10.1

## 10.1 Stakeholder Comments

The comments provided by all stakeholders from the initial consultation are summarised below.

##### Acuity

Concern was expressed by almost all stakeholders about the requirement for a doctor to assess medium and high level acuity patients before transport. The general view was that AV employed Division 1 Registered Nurse and Paramedics, and Division 1 Registered Nurses employed by the sending facility should be able to make the acuity assessment.

Acuity should be defined around the clinical needs of patients. The Regulations should recognise that not all patients of NEPT status require a stretcher.

If we could move more patients from emergency vehicles to NEPT vehicles it will allow for more timely services which will meet the patients’ needs better and provide more clarity and certainty for patients.

Define acuity in terms of medical needs, mobility and trauma treatment. Need to redefine acuity to be clear, e.g. may require active care en route (if not being transported for rehabilitation). Include frailty as a parameter of acuity.

The requirement for a stretcher vehicle as part of the definition of low acuity should be removed. This is an operational decision. Forcing a patient to be restrained on a stretcher when they are ambulant removes their dignity.

Allow use of Division 2 nurses for low acuity transports

Patient acuity is often higher than the vehicle is rated

Suggest changes to acuity into 4 classes - in line with AV

Inappropriate allocation of acuity results in substandard care.

Remove exemptions from staffing for all acuities. It is not in the interests of the patient.

Psychiatric high acuity does not need a critical care nurse

Require each NEPT provider to provide clinical support (appropriately qualified clinician) to crews – they can ring in for advice

##### Clinical Handover

The was a general view that a clinical handover for NEPT transport is required. Lack of handover prevents continuity of patient care. NEPT crews can be overlooked by hospitals and dispatchers.

Private hospitals are worse than public hospitals for handover.

Advanced Care Directives and Not for Resuscitation information are not always provided by the health service. A copy of any Not for Resuscitation Request should be provided to the NEPT crew as part of the clinical handover

Should be a standard form across all hospitals for patient transfer

NEPT crews should have a right to refuse to accept a patient if no clinical handover provided

##### Regulations

Current regulations are not outcome focussed and are far too prescriptive. Regulations should protect patients by focussing on quality of care standards.

The Regulations should provide flexibility and allow the licencees to determine the appropriate crew and equipment mix for their vehicles. This would allow for more efficient use of staff and vehicles. The responsibility and risk should be on the licencee.

A patient centred approach is supported

Separation between emergency and NEPT needs to be removed from legislation

NEPT laws apply to all including AV 000

##### Vehicles

The Regulations should have an outcome based requirement that all NEPT vehicles must carry the necessary equipment to manage the clinical needs of patients being transported. Currently the vehicles do not all have all the necessary equipment – e.g. suitable drugs.

Minimum equipment for all vehicles are Defib, Oxygen, Emerg response kit (rescus and bag valve masks) – Use QA to manage.

Only permit single load stretcher vehicles. Prohibit double loads

Delete current regulation about exterior signage

Vehicles should have access to AV communications device. Need to know how long it will take an emergency vehicle to arrive as can impact on patient treatment. Also need it to allow for conversation with triage person and AV clinician.

Vehicles must have space to carry luggage and mobility aids that are appropriately restrained.

Rural vehicles may need additional equipment in case a doctor is present to attend to patients.

Require a copy of the VicRoads certificate of compliance for each vehicle for build, fit out and restraints.

Air conditioning should be mandatory and effective

Engineering inspection for each vehicle annually and a copy of report provided to the Dept.

All vehicles need beacons as they may be used to protect an accident scene thus creating safety issues for crews, patients and emergency workers. Need warning lights and reflective jackets for all.

Define an emergency vehicle to include a NEPT vehicle fitted with warning devices and authorised by an AV clinician to proceed using warning devices if clinical condition of patient deteriorates and is considered an emergency.

##### Qualifications and training of staff

Replace qualifications requirement with a competencies requirement. E.g. a person may be certified as competent by a registered training organisation accredited with the national training authority (to include Recognition of Prior Learning).

Paramedic should be defined.

A Paramedic Bachelor degree should be required however we should grandfather existing qualifications that are the previous equivalent. The Diploma does not meet trauma patient needs.

Suggest should require a degree for medium and high acuity and higher patient needs.

Mandate qualifications in the regulations

Current ATO/PTO skills sets are suitable for Code 2 & 3 as currently allocated by AV.

Staff need to be familiar with a vehicle prior to working in it

Need to ensure staff have current competencies to deal with Code 2 & 3 calls.

Need an RPL process for assessing qualifications

Specify all crew must have medical qualifications

Maintain annual training and competency requirements

Require a driving component

Require minimum training. 400 hours very important. 400 hours should be over a maximum timeframe

Should be on road with clinical mentor then be assessed independently of the employer company.

Should there be AV oversight of NEPT training?

Continuous professional development should be required of crews

Clinical instruction should be available to crews

No tertiary course for NEPT clinical instructors exists. Training can only be obtained through AV

Clinical instruction is better suited to Clinical Nurse Educator

No bridging RN1 course available. Huge variation of internal courses offered to RN1s

Retain Patient Transport Officer as a minimum qualification

In the absence of national registration for Paramedics AV Paramedics should remain supported in their clinical practice by the AV Clinical Practice Development Committee and AV Medical Advisory Committee.

#### Scope of practice

Registered Health Practitioners be allowed to work to the scope of their practice provided the necessary equipment and support staff are provided. This would require changes to the Clinical Practice Protocols.

##### Licences

Any application for a licence should result in an assessment of the competence and capability of the applicant.

Should exclude operators with serious criminal convictions for a fixed period of time – not indefinitely as the court punishment is the penalty.

Fees should reflect the work carried out by the dept. If the same volume of work is carried out irrespective of the size of the NEPT then a flat fee should apply to each licencee. If the work is variable then variable fees should apply.

Variation of registration fee is too high

Base licence fees on transport numbers. Require annual reporting from licencees.

Flat fee for administration and a fee for inspection based on time spent.

Do individual vehicles need to be specified on the licence? If not should be listed in annual report to Dept.

Notify dept rather than vary licences if vehicle numbers change

Current fees do not reflect work involved by dept.

Manage fit and proper person with Statutory Declarations

##### Professional indemnity insurance

Should not include professional indemnity insurance

Retain requirement for medical indemnity

##### Accreditation and quality assurance

An accredited quality assurance plan should be required.

The Plan should include a range of matters such as:

* Infection control,
* Staff competencies and maintenance of competencies,
* Drugs security
* Cleaning and maintenance of vehicles
* Manual handling of patients,
* Carriage of personal belongings and mobility devices, etc.,
* Complaints management
* ACDs and NFRs processes
* Restraints
* Vehicle equipment
* Vehicle crewing

It should be up to the NEPT provider to design the processes, records control measures, etc. to suit their business and the requirements of their clients.

Quality assurance auditing should be undertaken by 3rd party health organisations accredited and lead auditors who understand patient safety and care.

Put ISO health safety & quality into QA plan for accreditation.

New applicants should provide a gap analysis

Maximum 6 month window to get accredited after initial licencing

Double loading should be addressed through the QA plan

Put infection control into QA plan

If put a lot of things into the QA plan will need to write a guide for auditors to ensure some level of consistency and appropriate auditing

Should be a 3 year audit cycle. A major audit initially and year 2 as a follow up to identified issues, and year 3 a targeted audit for important elements

Should include how to manage a crisis with a patient

Staff qualifications and competency should be managed through QA with external assessments by assessor trained to Cert 4 standard.

Require accreditation to National Safety and Quality Health Service Standards?

No Ebola training for staff in recent alert

##### Stand-by accreditation

Stand-by accreditation should be automatic for all NEPT licences and not require a separate application and fee.

Require a risk assessment for each event stand by services are provided at – to ensure service matches need.

Include criteria to be assessed for stand-by accreditation, e.g. skills, equipment, training relevant to the event

##### Enforcement

Unannounced visits to inspect vehicles should be part of the department’s activities – e.g. at a hospital emergency dept.

Department should be doing random inspections

How can hospitals be assured that NEPT standards are being maintained across the industry

Policing is critical

Want robust regulatory enforcement. Want adequate funding to DHHS to enable this to occur

##### Clinical Practice Protocols (CPPs)

Clinical Practice Protocols place some patients in the medium acuity bracket when their clinical needs require a Div. 1 nurse. Not consistent with the regulations.

CPPs should not discuss mobility in the context of acuity.

CPPs should not be mandatory as they are not keeping pace with clinical practice

In NSW & ACT NEPT providers can use the same drugs and protocols as the emergency ambulance service.

Clinical Practice Protocols are written to address medical patients and not trauma patients. Should address both.

CPPs should be updated annually by AV under contract to the Department (general support for this view)

AV Ambulance Community Officer guidelines are pretty close to the CPPs. ACOs have more drugs permissions than NEPT staff. Also education requirements for ACOs and NEPT staff are similar. AV could combine the two or take responsibility for reviewing and updating the CPPs.

Will be industry concerns about AV both being a contractor and a provider in this space and therefore they should not have responsibility for developing CPPs.

CPPs should be mandatory or else refer to or align with ACO guidelines

Not mandate CPPs and update more frequently so are kept current with clinical practice

Current CPPs not aligned with internal DHHS hospital policies

Current CPPs restrict clinical practice and are not in the best interests of patients

High acuity air CPPs well worded

CPPs force planes to run at high acuity due to risk to patient & organisation if there is an event while in transport.

ATO & AT are basic life support paramedics. Ambulance paramedics are ambulance life support paramedics. All should be able to work to scope of practice

Medical colleges should educate members on what CPPs require.

CPPs are causing underutilization of staff skills

Div 2 nurses not recognised but have more skills and knowledge than a PTO

CPPs requirement for a patient to be pain free for 2 hours prior to transport is difficult to manage

Ensure any updates/most recent information re infection control, resuscitation, etc. policies and procedures are referenced in the CPPs

##### Communication devices

Communication devices regulation should specify how the crews must be able to communicate with and with whom – not the specific device required

##### Drugs

Could put a schedule of permitted drugs for paramedics/NEPT in the Regulations. If so would need to regulate drugs governance and staff education.

Include s2 drugs and over the counter medications and adrenaline in the drugs permissions in the CPPs.

Analgesia – need intra nasal Fentanyl with suitable controls.

If NEPT to carry more drugs (s4 & S8?) would need separate education, independent verification of staff expertise and this should be included both as regs and in the QA plan.

NEPT could accept drugs for interhospital transport with suitable recording at pick up and drop off and unused drugs to be handed to the hospital.

Sedation of mental health patients should also be included

AV contract permits NEPT vehicles to be used for Code 1 emergencies. Vehicles do not carry the drugs they may need to deal with Code 1 incidents.

No to S8 permission without a Doctor on board. If to allow need GP clinical governance protocols

Look at permissions for S8s when paramedics are required to be registered with AHPRA – use a stepped approach

Sending hospital can give a standing order for S8/S11 drugs to be issued to crews for use during the transport with a handover and sign off with the receiving hospital for each transport.

More drugs required in high acuity

Escaped penthrane in the air can affect crews

Need access to anti emetics and pain relief

Allow RNs to administer drugs with a written order from the registered medical practitioner either employed by the sending hospital, or sub contracted by the NEPT provider, employed by ARV or working as independent retrieval specialists

Allow RNs to carry and administer emergency drugs such as Atropine, Adrenaline, Amiodarone, etc. as defined by the Australian Resuscitation Council or similar.

##### Patient Records

Consolidate patient record requirements for all acuities.

Remove requirements to record patient’s address for admitted patients

Include the name of the registered medical practitioner or RN1 that has assessed the patient as being haemodynamically stable for the duration of the transport

Remove requirement to provide contact detail of NEPT provider to each patient

##### Other

Manual patient handling protocols are important and should be kept current.

AV would like to send low risk Code 2 & 3 to NEPT with proper safeguards. NB: NEPT would need to have the necessary equipment and drugs to meet the clinical needs of these patients.

Should have an objective of “safe reliable service provision with regular service review that enables the clinical needs of patients to be met”.

Require annual report

NEPT is a dynamic industry. Skills are increasing. Regulations and CPPs have not kept pace with industry evolution

The industry can be more about logistics than patient care

Can a Compliance Code for NEPT be developed (say by union and AV) along the lines of a WorkSafe compliance code?

Regulations do not recognise that an NEPT vehicle may be flagged down at accidents, births, etc.

Health Purchasing Victoria is forcing lower costs potentially forcing providers to cut corners to make a profit – if so is risk to patients

NEPT are potentially the responders to emergency incident in rural areas

Could have a tiered approach to licencing and QA. Could we licence some NEPT providers for Code 2 & 3 emergencies?

Govt should return licence fees to the inspectorate to fund appropriate resourcing

DHHS could publish a list of quality measures on the website.

Would prefer to contract directly with hospitals and not through HPV

NEPT is not AV core business

Educate hospitals on NEPT – seems to be a lack of understanding

First aid providers at events should be regulated and licenced by DHHS

AV are requiring NEPT vehicles to be fitted out as an emergency vehicle an imposing unnecessary costs as a result.

##### Patient transport

If stretcher requirement removed it would allow for the Community Transport Scheme service at the low acuity end.

For inter hospital transfer the hospital appropriate GP or specialist can determine mode of transport & clinical care (e.g. NEPT with suitable medical staff or emergency vehicle).

High acuity vehicles should have one stretcher and two crew seats in the patient compartment.

Why require a doctor or nurse to accompanying high acuity patients to be from the sending hospital? Could be any GP or Critical Care Nurse with appropriate handover. Default currently is that AV emergency get called.

2 people should crew vehicles at all times where there is stretcher transport

One crew member should be monitoring in passenger compartment at all times

Aero cannot cope with significant deterioration of patient while in the air. A full triage of the patient prior to transport is required. Patients may be denied NEPT aero transport if there is a risk of deterioration during the journey.

Pressurised aircraft is required

For all rural transports a crew member should be with the patient at all times. All clinical monitoring of patients requires a crew member to be there.

Not permitting NEPT transport unless clinical monitoring with a crew member in the patient compartment will drive those who are not really NEPT into Clinic cars and taxis. What are the implications for contracts with AV for NEPT?

Require observations for all patients prior to NEPT pick up

Need for stretcher and crew numbers must be patient centred – what does the patient require?

Need a 2 person crew for a manual stretcher

Medium and high acuity patients must have 2 staff, one who is with the patient

Specify that for long distance low acuity transport 2 staff are required

A stretcher patient needs two staff so one can do the clinical monitoring

Double loaded vehicles – one patient may be unloaded to the side of the road if the other patient needs CPR

Medium acuity should be single stretcher

Crew should be empowered to make call on whether vehicle is matched to patient needs and whether double loading is appropriate. If there is potential for a low acuity patient to need more care then the crew should have the right to determine if patients should be double loaded – not the dispatcher or hospital

Double loading can mean that an infectious patient may travel with a non-infectious patient. Risk for Multiple Resistant Organisms? MRO patients should not be double loaded

Specify maximum load for a low acuity vehicle is 2 patients – to prevent triple loading as sometimes occurs

Double stretcher vehicles must provide room to move between patients

Can we use Residential Care Assistants for dementia patients – as need to be managed behaviourally?

Minimum of 2 staff for vehicle for both patient and staff safety. Or single staff must ring in every 2 hours. If staff member suffers injury or medical problem who can assist in a single crew vehicle? OH&S issue.

Psychiatric patients should be single transports. Transport could be done in a sedan for some people with ATO beside them.

Require a process for non English speaking transports. Permit family member to travel with patient

Is it necessary that only licensed and accredited units can transport patients? In many instances it may be suitable for the patient to be transported by taxi or for a fixed low amount (i.e. $50 each way) and paid for by the government. This could be organised by the healthcare provider.

Is it necessary that AV remain as the organisers of transporting patients?

Allow NEPT to transport emergency patients where a suitably qualified medical practitioner such as a qualified emergency intensive care physician (CPPs pg 9-11) escorts the patient.

Patients with GTN infusions should be transported by high acuity vehicles and Critical Care RN as patients with GTN are treated by hospitals in critical areas and not by RNs in wards.

Allow suitable qualified medical practitioners, not employed by the sending hospital to manage and escort patients.

##### Complaints

For contracted hospital to home service complaint often goes back to contractor not AV, but service is provided by AV who sub contract.

Should be an obvious way for patients and NEPT crews to report problems without retribution

Expand complaints process to provide a DHHS complaint contact number to patients and NEPT crews

Department should obtain NEPT complaint received by AV for review and planning purposes.

Need an information and behavioural standard to cover: complaints process, Customer service, quality of care, patient communication, and provision of interpreter service.

#### Next steps

The next stage of consultation is to invite responses to this RIS and the draft Regulations. The *Subordinate Legislation Act 1994* requires that the public be given at least 28 days to provide comments or submissions regarding the proposed Regulations. As there has already been a substantial initial round of consultation, the department considers that 28 days is adequate.

## 10.2 Further Questions

In developing this RIS, there has been ongoing consultation with stakeholders. In particular, the views of licencees, AV and United Voice have been sought on key changes to the 2005 Regulations. Stakeholder views and concerns already provided are summarised above in Section 10.

While this feedback has been helpful in identifying requirements that parallel ‘business as usual’ activities, the quantification of additional costs of the proposed Regulations is largely based on departmental assumptions where stakeholders have not been able to quantify the cost impacts.

A primary function of the RIS process is to inform members of the public and seek comment on the proposed Regulations before they are finalised. Comments on any aspect of the proposed Regulations are welcome. Stakeholders may wish to comment on the following consultation points in particular:

* The proposed Regulations aim to clarify what licenced NEPT providers are expected to do to meet the requirements under the Act. Do the proposed Regulations provide sufficient clarity? If not, in relation to which part of the Regulations would greater clarity be useful?
* The department considers that the improvements in the Regulations related to assessment of acuity, accreditation, scope of practice and staffing will result in prevention of at least 2 deaths per year (compared with an absence of regulations). Is this realistic?
* Overall, are there any practical difficulties in meeting any of the requirements set out in the regulations?
* Overall, are there any transitional or implementation issues associated with the proposed Regulations?
* The proposed Regulations propose an outcome based approach to staffing qualifications. The regulations specify minimum staffing requirements for NEPT vehicles. Do these Regulations provide sufficient clarity to proprietors? Are there circumstances where a Regulation does not offer sufficient flexibility to proprietors? If so, what is the additional cost of this? Are there alternative staffing options, either in regard to ratios or skill mix, that should be explored? Are the assumptions made in calculating the incremental costs of these requirements reasonable?
* Some Regulations were not analysed in this RIS as they are considered ‘business as usual’ for the sector (see Section 8) is this a reasonable assumption? Are there further incremental costs attributable to these Regulations not addressed?
* Do the proposed Regulations have any impacts on competition not identified in RIS?

**Written submissions are required by 5.00 pm Sunday 1 November 2015.**

# Appendix A: Cost assumptions and calculations

## A.1 Approach to assessing the regulatory options

In order to assess the options put forward in this RIS, an assessment is required of each option’s costs and benefits. The Victorian Guide to Regulation advises of the following principles in regards to conducting cost-benefit assessment:

* Before a particular regulatory proposal can be implemented, it needs to be demonstrated that the net benefits associated with the proposal are greater than the other approaches available to address the problem.
* Where possible, a dollar figure should be assigned to costs and benefits.
* Analysis should include an assessment of less tangible impacts (such as health and safety outcomes).
* Cost‐benefit analyses should also contain an assessment of risk to enable regulation to be in proportion to the risks involved.

The key objective in regulating non-emergency patient transport (NEPT) providers is to provide for the safety and quality of the services provided, and therefore protect the public that use them. For a range of reasons detailed in the RIS, non-emergency patient transport is a not a ‘typical market’ and therefore, government intervention in the form of regulation is warranted.

Due to the number of variables involved in the provision of NEPT, it is challenging to quantify the costs and benefits of regulation in this area. There is no baseline data available to measure intervention against. Licencing and regulation of private NEPT operators has been in place in Victoria for 10 years. No other Australian jurisdictions have a dedicated regulatory framework applied to NEPT.

The less tangible, social impacts of the proposed Regulations include:

* improved quality of life associated to the extent that Regulations lead to better health care
* greater transparency around safety and quality requirements
* benefits of providing better quality information to patients.

Non-quantifiable costs associated with the base case of no regulation include those associated with:

* a reduced confidence in the private system by patients
* decreased satisfaction by patients and health care professionals
* increased physical and psychological discomfort for patients
* decreased length or quality of life for patients.

The RIS makes some assumptions about preventable deaths, however quantifying the scale of avoidable harm that could be attributed to the proposed Regulations cannot be done in any robust way.

To assist in assessing the costs and benefits of the viable regulatory options, this RIS utilises the multi-criteria analysis (MCA) assessment tool. This is the preferred assessment approach where it is not possible to quantify and assign monetary values to all impacts of an option.

MCA involves identifying assessment criteria relevant to the intervention objectives, weighting these criteria and scoring alternative options against these criteria. An overall score is derived by multiplying the score assigned to each measure by its weighting and calculating the total. This provides a qualitative score for each option, and the option with the highest score represents the preferred approach.

The criteria weightings consider the relative importance each criterion in achieving the Regulations’ objectives. These values are necessarily subjective and informed by consultation with stakeholders and government policy.

The proposed Regulations and identified alternative approaches are scored relative to the base case. A scale of plus 10 (+10) to minus 10 (-10) was used, where 1 indicates a minimal positive impact and 10 indicates a high and material impact. This approach allows elements of the regulatory options to be differentiated in assessment. For example, if one option incurred costs of $2 million per year, and another option $4 million, then the former option might receive a rating of -5, while the latter would score -10.

#### General assumptions

Costs associated with complying with the Regulations will vary depending on the specific circumstances of each NEPT business.

The Regulations are not the only legislative framework or set of standards that require actions relating to patient safety and health care quality. As a result, a large proportion of NEPT providers are likely already in compliance with the Regulations; therefore, there will be minimal costs attributed to them.

Factors that may determine the extent of costs of compliance include: the resources of the business, the sophistication of the quality systems and level of staffing and management support around this.

Compliance costs for each category were estimated by:

* identifying additional (incremental) compliance tasks from the base case,
* identifying key activities required to complete compliance tasks; and
* valuing those activities based on staff time and/or cost of inputs.

The number of licenced NEPT providers has been increasing at an annual rate of 8.1% per annum since the Act and Regulations were first introduced. This rate has been taken as a proxy for the underlying rate of increase of NEPT transports annually over the next 10 years if industry settings remained the same as currently.

#### Valuing staff time

As a proxy for valuing an hour of a person’s time in the private NEPT sector the general formula referenced in the Victorian Guide to Regulation was used.

The formula states: **HRx = (AEx × OOx)/(AWx × AHx),** where:

**AEx** = average weekly earnings (trend full-time, adult, total earnings in Victoria) multiplied by 52 weeks

**AWx** = number of weeks worked per annum (44 weeks)

**AHx** = average weekly hours for full-time workers (41 hours)

**OOx** = multiplier for on-costs and overhead costs (1.75).

Actual wage rates in the various EBAs have been used to calculate staff time with the highest hourly rate being used as a proxy for ease of calculations. See calculations below.

**HRx**  = ([52 × 1,230] × 1.75) / (44 × 41)

 = ($63,960 × 1.75) / (44 × 41)

= 111,930 / 1804

 **= $62.05**

This general formula was used, rather than analysing specific data for each type of employee, because the incremental costs of Regulations will involve tasks completed by a range of workers, from nurses, NEPT crews, management, administration and finance staff.

#### Discount rate

In order to consider the cost of the Regulations over their potential life (10 years), the future costs are assessed using a ‘discount rate’. Applying a discount rate to future impacts allows them to be valued in today’s dollars (which, in turn, can be used to compare the costs and benefits of different options on a consistent basis). These amounts are known as the present values of future streams of benefits and costs.

The present value calculation is: PV = Σ Bt/(1+r)t where:

Bt is the benefit (or cost) at time period t

r is the discount rate

t refers to the year in which the benefit/cost impact occurs.

The department’s calculations:

* used a discount rate of 4.0 per cent as recommended by the Victorian Guide to Regulation
* assumed the number of private NEPT providers in Victoria to grow by 8.1 per cent per year. This figure is based on the growth in licence numbers between 2005 and 2015. NB: this is not the same as the growth in fleet sizes.

## A.2 Cost recovery and fee calculations

#### Table A 2.1 Issues

|  |  |  |
| --- | --- | --- |
| Step | Issues to be addressed | Departmental consideration |
| Appropriateness of cost recovery |
| 1 | Is provision of the output or level of regulation appropriate? | The Regulations are the minimum necessary to provide for the safety and quality for patient care and achieve the government’s objectives. |
| 2 | What is the nature of the output or regulation? | The Regulations are to ensure that private NEPT services are licenced with the department and that all NEPT services meet a range of standards in relation to patient safety and quality of care. |
| 3 | Who could be charged? | Potential parties to be charged are the proprietors of the NEPT services or the patients. Because the costs to government are directly linked to the licencing of the facilities operated by the proprietors, the department considers it appropriate that fees be levied on proprietors rather than patients. Further, the Act provides only that fees may be prescribed to charge on proprietors. |
| 4 | Is charging feasible, practical and legal? | Charging of fees is feasible and practical because it can be administered as part of the application processes. This also minimises transaction costs. The Act provides that fees may be prescribed. The fees are relatively low, and as such, noncompliance with licence requirements is expected to be minimal. |
| 5 | Is full cost recovery appropriate? | Yes — see Chapter 4 for the discussion. |
| Cost structures and nature of charges |
| 6 | Which costs should be recovered? | The cost base for the purposes of assessing recovery is based on the costs associated with the department administering the Act as it relates to processing licencing and other applications provided by proprietors. An activity-based costing method was used to determine the fee for each individual activity. |
| 7 | How should charges be structured? | The fees consist of a fee for applications that incorporate a fixed component for administrative charges and a variable component to reflect the likely amount of work required by the NEPT services dependent on their size. This is considered the most equitable approach. |
| Implementation features |
| 9 | What is the importance of consultation? | Consultation of fees is occurring via this RIS process. |
| 10 | How should cost-recovery arrangements be monitored and reviewed? | Requirements about the review of existing cost recovery arrangements are stipulated in the Standing Directions of the Minister for Finance under the Financial Management Act 1994.These directions require the chief financial and accounting officer of the department to document, approve and annually review the level of charges levied by the department for the goods and services it provides.  |

### Calculation of fees

The fully distributed cost method was adopted for determining the fee levels outlined in this RIS. It is recommended that this methodology should be used where cost recovery activities account for a large proportion of an agency’s activities. While regulation activities are not a large proportion of the department’s activities, it is the major activity of the Private Hospitals Unit. On this basis, the fully distributed cost method was adopted.

### Cost types

According to the Cost Recovery Guidelines, direct costs are those ‘that can be readily and unequivocally traced to a product or activity because they are incurred exclusively for that particular product/service’. On the other hand, indirect costs are not incurred exclusively for a particular product or activity. Fixed costs are unaffected by product or service delivery levels. Variable costs are directly related to the levels of production and service delivery.

For the purpose of determining the full costs incurred by the department in administering the regulatory scheme, costs have been categorised as follows:

* variable direct costs — these costs represent the salary costs (including on costs) associated with processing a particular type of application
* fixed direct costs (salary and operating) — these costs represent the ongoing costs of the program functions in the unit administering the regulatory scheme, such as compliance and education and policy costs; these costs are considered fixed
* indirect costs — these costs represent the corporate services costs, such as cost of operating database system.

The following hourly rates, which include on costs, were used for the salary costs

* VPS Grade 3 $53.62
* VPS Grade 4 $83.74
* VPS Grade 5 $76.60
* VPS Grade 6 $109.85
* EO 3 $131.82

The hourly rates were calculated as follows.

#### Table A 2.2 Salary hourly rates

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Position Level | Mid-point salary | Incl. On-cost & overheads (x1.75) | Cost per week (44 weeks) | Cost per day | Cost per hour |
| VPS 3 | $66,165 | $115,789 | $2,632 | $526 | $69.25 |
| VPS 4 | $80,006 | $140,011 | $3,182 | $636 | $83.74 |
| VPS 5 | $92,540 | $161,945 | $3,681 | $736 | $96.86 |
| VPS 6 | $120,098 | $210,172 | $4,777 | $955 | $125.70 |

The table was completed using the following assumptions:

* multiplier for on-costs and overhead costs is 1.75
* 44 week working year to account for public holidays, annual and sick leave
* 7.6 hours per business day.

An activity-based costing method was used to determine the variable cost for each individual activity.

This involved a step-by-step identification of the tasks undertaken by the department to process an application for which a fee is proposed to be set is required. Under this analysis, each task is assigned a time in minutes, a VPS salary grade of the person(s) undertaking the task and the resulting cost of each task. These costs are totalled, giving an overall variable direct cost of processing one application.

The estimates of time are based on the department’s expectation of performance and have been informed by current practices.

The fixed costs have been attributed to the licence application and renewal activities, because the majority of the department’s regulatory activity in this area revolves around these requirements, and they represents the greatest revenue for the department.

The elements involved in processing and assessing application are continually reviewed by the department for efficiency and effectiveness and are currently considered to be the most efficient way of undertaking these processes. As improvements are identified processes will be updated and any savings of note will be factored into to future fees.

The costs to the applicant of applying for a new licence or licence renewal have not been calculated as this is a requirement of the Act and not the Regulations.

### Option A

##### Approval-in-principle

The Act includes provision (via Section 8) for a person to opt to apply to the Secretary for an ‘approval-in-principle’ (AIP) prior to licencing. This is designed to provide a level of assurance to enable a person to know, prior to the commitment of resources and time, whether an application to licence is likely to be successful. The process involves assessment of the governance arrangements, the location of the vehicle garaging, the equipment storage and the condition of the vehicles. The department’s Senior Nurse Advisor undertakes the assessments. There has never AIP application since the 2005 Regulations (and Act) were introduced.

A theoretical calculation to cost AIP has been provided in order to set a fee for application for AIP. In practice if there are no applications no fees can be charged.

Table A 2.3

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks – Approval in Principle | Staff tariff | Time (per hour) | Cost $ |
| **VARIABLE COSTS** |  |  |  |
| Telephone / email queries | $96.86 | 1 | 96.86 |
| Pre-AIP meeting with proprietor. | $96.86 | 1 | 96.86 |
| Receive application, stamp, file and enter into database  | $96.86 | 0.5 | 48.43 |
| Scan and record documents  | $96.86 | 0.25 | 24.22 |
| Check for completeness and assess against checklist | $96.86 | 1 | 96.86 |
| Follow up applicant by phone/email if required | $96.86 | 0.5 | 48.43 |
| Processing fee including invoice request and approval | $96.86 | 0.75 | 72.65 |
| Full application assessment  | $96.86 | 1 | 96.86 |
| Preparation of brief and certificate for assessment  | $96.86 | 1 | 96.86 |
| Application package to be approved by manager  | $125.70 | 0.5 | 62.85 |
| Once signed, approval letter generated  | $96.86 | 0.4 | 38.74 |
| Certificate and correspondence finalised and sent registered post | $96.86 | 0.4 | 38.74 |
| Email of certificate and approval letter to applicant  | $96.86 | 0.25 | 24.22 |
| Update all files (hardcopy, internal drives and database) | $96.86 | 0.5 | 48.43 |
| Contact applicant to arrange AIP site inspection | $96.86 | 0.5 | 48.43 |
| Email applicant with information required prior to site inspection | $96.86 | 0.5 | 48.43 |
| Arrange inspection  | $96.86 | 0.75 | 72.65 |
| SNA site visit and advice | $96.86 | 3 | 290.58 |
| Prepare correspondence to establishment | $96.86 | 1 | 96.86 |
| Receive proof of outstanding items and document | $96.86 | 0.3 | 29.06 |
| Send a follow up email/phone call to establishment if required | $96.86 | 0.3 | 29.06 |
| Finalise the AIP by updating the database and hard copy file  | $96.86 | 0.25 | 24.22 |
| **FIXED COSTS** |  |  |  |
|  Guidance Material development | $96.86 |  1 | 96.86  |
| Contract management, compliance and enforcement | $96.86 | 1 | 96.86 |
| **TOTAL** |  |  | **$1,724.02**  |

### Variation or transfer of approval-in-principle

Under Section 12 of the Act, the person who holds the original AIP certificate can apply to have this varied (for example, if there are changes in the location), or to transfer the certificate to another person (where there is a change of proprietor). This process is less involved than the original AIP process and does not require an onsite visit. Variations and transfers of AIP have never occurred.

#### Table A 2.4

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks - Variation or transfer of Approval in Principle | Staff tariff | Time (per hour) | Cost $ |
| Telephone / email queries | $96.86 | 0.5 | 48.43 |
| Receive application, stamp, file and enter into database  | $96.86 | 0.2 | 19.37 |
| Scan and record documents  | $96.86 | 0.2 | 19.37 |
| Check for completeness and assess against checklist | $96.86 | 0.5 | 48.43 |
| Follow up applicant by phone/email if required | $96.86 | 0.25 | 24.22 |
| Processing fee including invoice request and approval | $96.86 | 0.25 | 24.22 |
| Full application assessment  | $96.86 | 0.75 | 72.65 |
| Preparation of brief and certificate for assessment  | $96.86 | 1 | 96.86 |
| Application package to be approved by manager  | $125.70 | 0.3 | 37.71 |
| Once signed, approval letter generated  | $96.86 | 0.3 | 29.06 |
| Certificate and correspondence finalised and sent registered post | $96.86 | 0.4 | 38.74 |
| Email of certificate and approval letter to applicant  | $96.86 | 0.5 | 48.43 |
| Update all files (hardcopy, internal drives and database) | $96.86 | 0.5 | 48.43 |
|  |  |  |  |
| **TOTAL** |  |  | **556.00**  |

### Initial licence fee

Sections 13–19 of the Act provide for the licencing of private NEPT services.

Under the Act, the applicant must provide evidence that they meet the criteria for licencing detailed earlier in this RIS. The activity base for the initial licence fee includes the tasks involved, including a site visit by the senior nurse advisors. On average, the department receives applications from one new service per year.

#### Table A 2.5

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks - Initial Licence Fee | Staff tariff | Time (per hour) | Cost $ |
| Telephone / email queries | $69.25 | 0.08 | 5.54 |
| Provision of information via email | $69.25 | 0.24 | 16.62 |
| Arrange establishment visit and provide advice documents | $96.86 | 0.5 | 48.43 |
| Pre visit preparation | $96.86 | 1.75 | 169.51 |
| Tasks - Initial Licence Fee | Staff tariff | Time (per hour) | Cost $ |
| Revise and reschedule (15 % av.) | $96.86 | 0.34 | 32.93 |
| Inspection and report | $96.86 | 8.0 | 774.88 |
| Review of policies and procedures | $96.86 | 3.0 | 290.58 |
| Letter of outcomes issued | $96.86 | 1 | 96.96 |
| Receipt of action plan  | $96.86 | 0.425 | 41.17 |
| 2nd visit if required | $96.86 | 1.14 | 110.42 |
| Receive application, stamp, file and enter into database | $69.25 | 0.25 | 17.31 |
| Check for completeness and assess against checklist | $69.25 | 0.16 | 11.08 |
| Follow up applicant by phone/email if required | $69.25 | 0.08 | 5.54 |
| Discussion with Manager PHU | $69.25 | 0.08 | 5.54 |
| Preparation of brief with reference to inspection outcomes | $69.25 | 1 | 69.25 |
| Processing payment of fee | $69.25 | 0.16 | 11.08 |
| Prepare certificate for applicant | $69.25 | 0.08 | 5.54 |
| Application package to be approved by manager PHU | $125.70 | 0.25 | 31.43 |
| Application package to be approved by Director | $186.57 | 0.25 | 46.64 |
| Update all files (hardcopy, internal drives and database) | $69.25 | 0.25 | 17.31 |
| Certificate and correspondence finalised and sent registered post | $69.25 | 0.25 | 17.31 |
| Development of guidance materials | $96.86 | 0.5  | 48.43 |
| Education and support to registrants | $96.86 | 1 | 96.86 |
| Website and information management  | $69.25 | 1 | 69.25 |
| Review of Gap Analysis or Quality Assurance Program  | $125.70 | 2 | 251.40 |
| Ministerial/Consumer/Stakeholder enquiries and advice | 69.25x196.86x1125.70x0.5 | 2.5 | 228.96 |
| **TOTAL** |  |  | **$2,519.87**  |

Licence renewal (over two-year cycle as specified by the Act)

Sections 21-23 of the Act provide for licence renewal. As the renewal applies for two years, the activity based costing below covers the two-year cycle of activities plus the fixed program costs.

#### Table A 2.6.

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks - Licence Renewal | Staff tariff | Time (hr) | Cost $ |
| **VARIABLE COSTS** |  |  |  |
| Determining renewal visit schedule | $96.86 | 0.18 | 17.43 |
| Arrange establishment visit and provide advice documents | $96.86 | 0.50 | 48.43 |
| Pre visit preparation | $96.86 | 1.75 | 169.51 |
| Revise and reschedule (15 % av.) | $96.86 | 0.34 | 32.93 |
| Inspection and report | $96.86 | 8 | 774.88 |
| Letter of Outcomes issued | $96.86 | 1 | 96.86 |
| Receipt of action plan  | $96.86 | 0.43 | 41.65 |
| 2nd visit if required | $96.86 | 1.14 | 110.42 |
| Receive application, stamp, file and enter into database | $69.25 | 0.50 | 34.63 |
| Check for completeness and assess against checklist | $69.25 | 1.50 | 103.88 |
| Follow up applicant by phone/email if required | $69.25 | 0.15 | 10.39 |
| Discussion with Manager PHU | $69.25 | 0.25 | 17.31 |
| Preparation of brief with reference to inspection outcomes | $69.25 | 1.00 | 69.25 |
| Review of annual report | $96.86 | 2.0 | 193.72 |
| Review of prescribed elements of the quality assurance program | $96.86 | 3.0 | 290.58 |
| Processing payment of fee | $69.25 | 0.50 | 34.63 |
| Prepare certificate for applicant | $69.25 | 0.25 | 17.31 |
| Application package to be approved by manager PHU | $125.70 | 0.25 | 31. 43 |
| Application package to be approved by Director | $186.57 | 0.25 | 46.64 |
| Update all files (hardcopy, internal drives and database) | $69.25 | 0.25 | 17.31 |
| Certificate and correspondence finalised and sent registered post | $69.25 | 0.25 | 17.31 |
| **FIXED COSTS** |  |  |  |
| Development of guidance materials | $96.86 | 0.5 | 48.43 |
| Education and support to registrants | $96.86 | 1 | 96.86 |
| Complaints and incident review and management | $96.86 | 1 | 96.86 |
| Website and information management  | $69.25 | 1 | 69.25 |
| Management of issues identified  | $125.70 | 1 | 125.70 |
| Ministerial/Consumer/Stakeholder enquiries and advice | 69.25x196.86x1125.70x0.5 | 2.5 | 228.96 |
| **TOTAL** |  |  | **$2,811.13** |

### Transfer or Variation of registration

Sections 26-28 of the Act provides for variation of a licence. This occurs, for example, when the number of vehicles operated by the service changes. A site visit may be associated with this to view the new vehicles, but this can also be done remotely over Skype. Therefore, the activities listed below are only those associated with processing the variation of the licence.

#### Table A 2.7

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks - Variation or transfer of licence | Staff tariff | Time (per hour) | Cost $ |
| Telephone / email queries | $96.86 | 0.16 | 15.50 |
| Generation of reminder letters and invoice | $96.86 | 0.08 | 7.75 |
| Receive application, stamp, file and enter into database | $96.86 | 0.5 | 48.43 |
| Check for completeness and assess against checklist | $96.86 | 1.5 | 145.29 |
| Follow up applicant by phone/email if required | $96.86 | 0.75 | 72.65 |
| Discussion with Manager PHU | $96.86 | 0.25 | 24.22 |
| Preparation of brief with reference to inspection outcomes | $96.86 | 1 | 96.86 |
| Processing payment of fee | $69.25 | 0.5 | 34.63 |
| Prepare certificate for applicant | $69.25 | 0.25 | 17.31 |
| Application package to be approved by manager PHU | $125.70 | 0.25 | 31.43 |
| Application package to be approved by Director | $69.25 | 0.25 | 17.31 |
| Update all files (hardcopy, internal drives and database) | $69.25 | 0.25 | 17.31 |
| Certificate and correspondence finalised and sent registered post | $69.25 | 0.75 | 51.94 |
| Issuing processing and documentation | $69.25 | 0.5 | 34.63 |
| **TOTAL** |  |  | **$615.26** |

### Stand-by accreditation

#### Table A 2.8

|  |  |  |  |
| --- | --- | --- | --- |
| Tasks – Accreditation for Stand-by | Staff tariff | Time (per hour) | Cost $ |
| Telephone / email queries | $96.86 | 0.16 | 15.50 |
| Generation of letters and invoice | $96.86 | 0.08 | 7.75 |
| Tasks – Accreditation for Stand-by | Staff tariff | Time (per hour) | Cost $ |
| Receive application, stamp, file and enter into database | $96.86 | 0.5 | 48.43 |
| Check for completeness and assess against accreditation criteria | $96.86 | 1.0 | 145.29 |
| Follow up applicant by phone/email if required | $96.86 | 0.75 | 72.65 |
| Discussion with Manager PHU | $96.86 | 0.25 | 24.22 |
| Preparation of brief with reference to assessment outcome | $96.86 | 1 | 96.86 |
| Processing payment of fee | $69.25 | 0.5 | 34.63 |
| Prepare certificate for applicant | $69.25 | 0.25 | 17.31 |
| Application package to be approved by manager PHU | $125.70 | 0.25 | 31.43 |
| Application package to be approved by Director | $69.25 | 0.25 | 17.31 |
| Update all files (hardcopy, internal drives and database) | $69.25 | 0.25 | 17.31 |
| Certificate and correspondence finalised and sent registered post | $69.25 | 0.25 | 17.31 |
| Issuing processing and documentation | $69.25 | 0.75 | 51.94 |
| **TOTAL** |  |  | **$597.94** |

**Table of costs apportioned with fixed program costs included**

Cost of licence renewal per facility is $2,811.13 on average

Total income must be $2,811 x 20 = $56,220 over 2 years

#### Table A 2.9 Proposed licence renewal fees

|  |  |  |  |
| --- | --- | --- | --- |
| Vehicle numbers | No. of licencees | Licence fee | Total income |
| 1-9 | 13 | $1,811  | $23,543  |
| 10-49 | 4 | $3,811  | $15,244  |
| 50+ | 3 | $5,811  | $17,433  |

**Total $56,220**

Total fees charged per annum are:

1 x $2,520 (initial licence fee) + 10 x $2,811 (annual renewal fees for half the licencees) + 1 x $615 (variation of registration) 1 x $615 (transfer of registration) + 7 x $598 (1 new and 6 renewed stand-by accreditation fees)

=$2,520 + $28,110 + $615 + $615 + $4,186

= $36,046 p.a.

#### Table A2.10 Proposed fees

|  |  |  |
| --- | --- | --- |
| Application type | Fee ($) | Fee units |
| Fee for application for approval in principle (AIP) | 1,727.20  | 127  |
| Fee for variation or transfer of certificate of AIP | 557.60  | 41  |
| Application for Licence | 2,516.00  | 185  |
| Renewal of Licence |  |  |
| 0-9 vehicles | 1,808.80  | 133  |
| 10-49 vehicles | 3,808.00  | 280  |
| 50+ vehicles | 5,807.20  | 427  |
| Application for variation or transfer of licence | 612.00  | 45  |
| Stand-by accreditation application or renewal | 598.40 | 44 |

### Cost to NEPT licencees of applying for registration and renewal of registration

There are costs incurred by applicants for NEPT licences or renewal of licences in providing the necessary documentation prescribed by the Regulations. These are set out below. Staff costs are ascribed at $52.50 per hour.

#### Table A2.11 Licence renewal costs

|  |  |  |
| --- | --- | --- |
|  Licence Application or Renewal | Time (hr/mins) | Cost $ |
| Fill in application | 0.15 | 13.13 |
| Obtain ASIC company extract documentation | 0.15 | 13.13 |
| Fill out Directors declaration forms | 1.00 | 52.50 |
| Provide a complete company chart where the company is a subsidiary company | 0.15 | 13.13 |
| Complete statutory declarations for each natural person or director and officer of a body corporate | 2.0 | 105.00 |
| Obtain 2 written references for each natural person or director and officer of a body corporate  | 2.0 | 105.00 |
| Obtain a police check for each natural person or director and officer of a body corporate | 1.0 | 52.50 |
| Obtain a statement of financial capacity of the proposed licenced holder from a CPA or ACA | 0.15 | 13.13 |
| Provide a copy of the Certificate of Registration of the business name of the proposed licence holder | 0.15 | 13.13 |
| Provide copies of prescribed elements of the quality assurance plan | 0.30 | 26.25 |
| Provide Vic Roads Certificate of compliance for all new vehicles | 0.15 | 13.13 |
| Provide a copy of the gap analysis or the certificate of accreditation | 0.15 | 13.13 |
| **Total** |  | **$433.16** |

There is one new licence application and 10 applications to renew a licence each year so the annual cost is: 11 x $433.16 = $4764.76 p.a. for the sector. The cost has been included in the overall discounted cost calculations.

#### Table A2.12 Projected incremental cost of fees for proposed Regulations over ten years

These costs comprise $36,046 (licence fees) and $4765 (licence application costs) = $40,811

|  |  |  |
| --- | --- | --- |
| Year | Cost $ | Discounted cost $ |
| 2015–16 | 40,811  | 39,241  |
| 2016–17 | 44,117  | 40,788  |
| 2017–18 | 47,690  | 42,397  |
| 2018–19 | 51,553  | 44,068  |
| 2019–20 | 55,729  | 45,805  |
| 2020–21 | 60,243  | 47,611  |
| 2021–22 | 65,123  | 49,488  |
| 2022–23 | 70,398  | 51,439  |
| 2023–24 | 76,100  | 53,467  |
| 2024–25 | 82,264  | 55,575  |
| **TOTAL** | **594,028**  | **469,879**  |

## A.3 Calculations and assumptions for costs/savings of broadening the range of people who may assess patient acuity

### Option A

Ambulance Victoria advise that this change will result in more than 50,000 patient transports annually being redirected to the non-emergency sector away from the emergency sector. The bulk of these transports will be triple zero calls with some additional transports from residential accommodation (aged care, disability care, etc.) also being redirected.

This change will have a number of cost impacts:

* The cost of patient trips will be charged at the non-emergency transport rate instead of the emergency transport rate.
* Emergency vehicles will be freed up to attend emergencies with a resulting improvement in Code 1 response times.
* Reduced waiting times for emergency vehicles are estimated to result in the saving of a least 2 lives per annum.
* Reduced and more reliable waiting times for NEPT transports contracted through AV.
* Hospitals will be able to better manage patient discharge and transfers via NEPT which will result in increased turnover of beds and reduced ramping at emergency Departments

#### Cost impact of increased numbers of patient trips

Current cost of AV NEPT metropolitan road transport is: $309

Current cost of AV NEPT regional and rural road transport is: $523

Current cost of AV emergency metropolitan road transport is: $1,146

Current cost of AV emergency regional and rural road transport is: $1,690

The division (13/14 year) between metropolitan and regional and rural emergency transport is 383,863 metropolitan emergency road transports and 168,405 regional and rural emergency transports, a ratio of approximately 7:3. For the purposes of this calculation is it assumed that all regional and rural transports to be directed to NEPT are road transports.

The figure of 50,000 transports redirected to NEPT has been used as the basis for calculating the savings to patients resulting from the expansion of who can make acuity assessments.

Metropolitan road transports - $1,146 - $309 x (70% x 50,000) = $29,295,000

Rural and Regional transports - $1,645 - $523 x (30% x 50,000) = $16,830,000

**The total saving to patients is estimated at $29,295,000 + $16,830,000 = $46,125,000 p.a.**

This amount is also a cost attributable to the current regulations and therefore forms part of the cost of option B.

The Ambulance Victoria website states that AV operate more than 300 road ambulances and in the 2013-14 year attended 552,268 emergency road incidents. Reducing the road incident attendance by more than 50,000 attendances and directing them to NEPT transports would allow an increase in emergency road response capacity resulting in improved Code 1 response times. These improvements would also be expected to result in in reduced bed blocking in hospitals and reduced ambulance ramping provided vehicle numbers are unchanged.

It would be expected that any reduction in demand for emergency vehicles would enable a quicker response to Code 1 transports. While it is not possible to presume that ambulance delays resulting in the death of patients would cease, and it not possible to know if these patients would have survived with a rapid ambulance response, it is noted that if just 2 lives were saved each year and the patients lived for an additional 10 years as a result the overall saving to the community would be: 2 x $182,170 (value of a statistical life year) x 10 = $3,643,400. The rationale for using 2 lives as the proxy is explained in the RIS.

A saving will result due to the reduced demand on emergency vehicles as a result of this regulation which in turn will mean an improved Code 1 response time with at least 2 deaths prevented per annum. As described above we have assumed a net benefit of $3,643,400 overall.

The number of patient transports undertaken by a single NEPT crew and vehicle in the metropolitan area is estimated at **1,276 trips per annum**. (0.7 jobs per hour x 38 hours per week x 48 weeks).

In order to meet the demand created by a potential extra 50,000 patient transports per annum in year 1 it is estimated at least 39 additional vehicles and crews will be required to be supplied by private NEPT operators **(50,000 transports ÷ 1276 trips per vehicle = 39 additional vehicles and crews required).** This is equivalent to an 11% expansion of the private NEPT sector.

Note: the additional vehicles would be required by only those NEPT companies that are contracted to AV to provide NEPT transports and the changes would require a transition period.

The provision of extra vehicles is not calculated as a cost imposed by the Regulations as it is not a regulatory requirement. Rather it is a business opportunity licencees may or may not take up. It will also create the opportunity for new entrants to the market.

#### Table A 3.1 10 Year Incremental community benefit of Option A

|  |  |  |
| --- | --- | --- |
| Year | Saving $ | Discounted Saving Option A $ |
| 2016-17 | 3,643,400 | 3,503,269 |
| 2017-18 | 3,938,515 | 3,641,379 |
| 2018-19 | 4,257,535 | 3,784,933 |
| 2019-20 | 4,602,395 | 3,934,147 |
| 2020-21 | 4,975,189 | 4,089,243 |
| 2021-22 | 5,378,179 | 4,250,454 |
| 2022-23 | 5,813,811 | 4,418,019 |
| 2023-24 | 6,284,730 | 4,592,191 |
| 2024-25 | 6,793,793 | 4,773,230 |
| 2025-26 | 7,344,090 | 4,961,405 |
| **TOTAL** | **53,031,637** | **41,948,270** |

**The 10 year discounted community benefit of option A is $41,948,270**

### Option B

The cost of Option B in year one would be $46,125,000 + $3,643,400 = $49,768,400 (cost of the current regulation referred to in Table A 3.2 below).

#### Table A 3.2 10 year Incremental Cost of Option B

|  |  |  |
| --- | --- | --- |
| Year | Saving $ | Discounted cost of Option B $ |
| 2016-17 | 49,768,400 | 47,854,230 |
| 2017-18 | 53,799,640 | 49,740,791 |
| 2018-19 | 58,157,410 | 51,701,725 |
| 2019-20 | 62,868,160 | 53,739,969 |
| 2020-21 | 67,960,480 | 55,858,565 |
| 2021-22 | 73,465,278 | 58,060,681 |
| 2022-23 | 79,415,965 | 60,349,614 |
| 2023-24 | 85,848,658 | 62,728,784 |
| 2024-25 | 92,802,399 | 65,201,748 |
| 2025-26 | 100,319,390 | 67,772,202 |
| **TOTAL** | **724,405,780** | **573,008,309** |

**The incremental costs of option B are estimated at $573 million over the life of the Regulations.**

## A.4 Calculations and assumptions for options to regulate staffing

In calculating the incremental costs the following data and estimations were used:

* Estimated that under the base case 90 per cent of proprietors are employing staff who are professionally competent. Therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations.
* Estimated that under the base case 90 per cent of proprietors are employing sufficient numbers of NEPT staff on duty. Therefore, 10 per cent of the cost of the sector meeting this requirement is attributable to the Regulations.
* There are 20 licenced private NEPT providers, with a total of 339 vehicles and 5 aircraft that undertake approximately 350,000 patient transports per year.
* The total NEPT workforce crewing vehicles is estimated at 688 staff.
* NEPT crews usually operate one shift per day, however overtime may occur.
* The hourly wage rate calculated earlier is $62.05.

**NB: Overtime is not included in the calculations.**

### Incremental costs of employing sufficient number of NEPT staff with sufficient skill mix and qualifications

* ‘Sufficient’ is defined in the proposed Regulations as using enough crew members to meet the clinical needs of the patient during transport. The average crew numbers have been calculated at 2 crew members per vehicle although it is noted that some low acuity transports will only require 1 crew member and some high acuity transports will require 3 crew members.
* Skill mix is not prescribed but is required through an outcome based regulations that requires all staff transporting patients to have the necessary competence, qualifications and skills to manage the clinical needs of the patient being transported.
* Because it is estimated that 90 per cent of proprietors would meet this requirement under the base case, the incremental cost calculating the cost attributable to the 10 per cent who would need further staffing or improved qualifications of staff under the Regulations.
* It is assumed that under the base case the 10 per cent would seek to have fewer NEPT staff than the patient requires. The average of 50 per cent fewer staff (1 crew member instead of 2 crew members) is used for the purposes of estimating costs.

#### Base Case

**The base case is calculated at $2,844,000 pa.**

##### Cost of allocating a second vehicle:

5% x 150,000 x $200 + 5% X 150,000 x 2% x $8,960 = $2,844,000 per annum.

#### Table A 3.1 Cost of Base Case

|  |  |  |
| --- | --- | --- |
| Year | Cost $ | Discounted cost of Base Case $ |
| 2016-17 | 2,844,000  | 2,734,615  |
| 2017-18 | 3,074,364  | 2,842,422  |
| 2018-19 | 3,323,387  | 2,954,479  |
| 2019-20 | 3,592,581  | 3,070,954  |
| 2020-21 | 3,883,580  | 3,192,020  |
| 2021-22 | 4,198,150  | 3,317,859  |
| 2022-23 | 4,538,200  | 3,448,660  |
| 2023-24 | 4,905,794  | 3,584,616  |
| 2024-25 | 5,303,163  | 3,725,933  |
| 2025-26 | 5,732,719  | 3,872,821  |
| **TOTAL** | **41,395,938**  | **32,744,379**  |

### Option A

Incremental cost of the Regulations:

344 vehicles, assuming full use for 1 shift daily.

100% compliance @ 2 staff per vehicle = 688 staff.

90% compliance @ staff per vehicle = 619 staff.

Assuming the remaining 10% operating with 1 crew member = 35 staff.

Total staff (619+35) = 654 staff.

Incremental cost would be an additional 35 staff per shift per day.

35 × $2,544 x 44 = $3,917,837 per year for a single daily shift.

#### Table A 4.2 Cost of Option A

|  |  |  |
| --- | --- | --- |
| Year | Cost $ | Discounted cost of Base Case $ |
| 2016-17 | 3,917,837 | 3,767,151 |
| 2017-18 | 4,235,182 | 3,915,664 |
| 2018-19 | 4,578,232 | 4,070,031 |
| 2019-20 | 4,949,069 | 4,230,485 |
| 2020-21 | 5,349,944 | 4,397,264 |
| 2021-22 | 5,783,289 | 4,470,618 |
| 2022-23 | 6,251,735 | 4,750,806 |
| 2023-24 | 6,758,126 | 4,938,097 |
| 2024-25 | 7,305,534 | 5,132,772 |
| 2025-26 | 7,897,282 | 5,335,122 |
| **TOTAL** | **57,026,230** | **45,008,010** |

Incremental cost of Regulations (Option A) = $45,008,010 (10 year discounted cost)

**Therefore the net benefit of Option A when compared to the base case is:**

 **$32,744,379 - $45,008,101 = $12,263,722 10 year discounted net cost**

## A.5 Accreditation

Quality Assurance Plans seek to drive the implementation and use of safety and quality systems and improve the quality of outputs of the business. In the Case of NEPT services the aim of accreditation of QA Plans is to continually improve health service provision delivered by the licencees. Because of the variable size, structure and complexity of NEPT licencees, a degree of flexibility is required in the development of the QA plans so that the plan is tailored for the business. Minimum inclusions will be prescribed however the licencee will determine the content of each of the prescribed inclusions.

The minimum prescribed inclusions are:

* Infection control,
* Active clinical monitoring of patients
* Management of critical issues
* Management of patient emergencies
* Staff qualifications and training
* Staff competencies and maintenance of competencies and assessment of competencies by a registered training organisation
* Standardisation of qualifications and experience
* Patient communication
* Access to clinical advice for crews who are off site
* Drug security including storage, use, disposal and records,
* Manual handling of patients,
* Patient records,
* Carriage of personal belongings and mobility devices, etc.,
* Complaints management
* Clinical Handover including ACDs and NFRs processes
* Vehicle equipment
* Vehicle crewing
* Vehicle & equipment maintenance plan
* Vehicle & equipment cleaning program
* Complaints register and investigation process

and the QA Plan must contain policies, procedures, records, review processes for each matter.

### A 5.1 Costing

#### Obtaining accreditation

There are seven licencees that will be required by the regulations to obtain accreditation who would not otherwise have needed to do so and there will be one new licencee per annum. On the basis that these businesses are small and would not otherwise be required to be accredited the costs are outlined below.

Annual audit cost is $2,000

Annual Certification Cost is $1600

Initial QA plan preparation is $7,500

QA plan maintenance is $2,500

The cost of developing a QA plan and obtaining accreditation is estimated at $7,500 + $3600 = **$11,100**

The cost of maintaining a QA plan and obtaining accreditation is estimated at $2,500 + 3600 = **$6,100**

Therefore 8 (7 existing and one new licencee) = $11,100 + 8 x $6,100 = **$59,900 p.a.**

It is also likely that the licencees who are not contracted by AV will be need to upgrade their Quality Assurance Plan to meet the prescribed requirements. There would be an additional three licencees affected in this way and these would be likely to be larger operators with more complex businesses.

It is estimated it would take one full time weeks work for these businesses to upgrade the plans to a suitable standard to be accredited under the new regulation.

Therefore 3 (licencees) x 38 hours x $62.05 = **$7,074**

### Gap analysis

It is estimated that there will be one new licence application per year. Therefore one applicant per year will be required to obtain a gap analysis if they do not achieve accreditation prior to licencing. A gap analysis consists of the applicant engaging an accreditation agency to review the draft quality assurance plan and identify the gaps that require addressing to enable the plan to be of a suitable standard to be accredited.

A gap analysis would take between one and two days. Accreditation agency fees range between $1,500 to $2,500 per day. For the purposes of the cost analysis a midpoint figure of $2,000 has been used.

Therefore 1 licencee x $2,000 per day x 1.5 days = **$3,000**

The total cost of the requirement therefore is:

$59,900 + $7074 + $3,000 = **$69,974 per annum**

#### Table A 5.1 The 10 year discounted cost of Option A

|  |  |  |
| --- | --- | --- |
| Year | Cost $ | Discounted Cost |
| 2015-16 | 69,974 | 67,283 |
| 2016-17 | 75,642 | 69,935 |
| 2017-18 | 81,769 | 72,692 |
| 2018-19 | 88,392 | 75,558 |
| 2019-20 | 95,552 | 78,537 |
| 2020-21 | 103,292 | 81,633 |
| 2021-22 | 111,658 | 84,851 |
| 2022-23 | 120,702 | 88,196 |
| 2023-24 | 130,479 | 91,673 |
| 2024-25 | 141,048 | 95,287 |
| **TOTAL** | **1,018,508** | **805,645** |

**The 10 year incremental cost for option A, the proposed regulation, is $805,645**

# Appendix B: Ambulance Charging Guidelines

To be attached

# Appendix C: Draft Regulations

To be attached

1. WHO, Quality of Care, A process for making Strategic Choices in Health Systems, 2006. [↑](#footnote-ref-1)
2. Department of Prime Minister and Cabinet Office of Best Practice Regulation, December 2014, Best Practice Regulation Guidance Note: Value of a Statistical Life. [↑](#footnote-ref-2)
3. ACIL Allen Consulting, The Non-emergency patient review final report, 2013 [↑](#footnote-ref-3)
4. The criteria which must be considered by the Secretary are set out fully in Section 15 of the NEPT Act 2003. [↑](#footnote-ref-4)
5. ACIL Allen Consulting, The Non-emergency patient review final report, 2013 [↑](#footnote-ref-5)
6. Ambulance Victoria 2013-14 Annual Report [↑](#footnote-ref-6)
7. ACIL Allen Consulting, The Non-emergency patient review final report, 2013 [↑](#footnote-ref-7)
8. WA Health Patient Transport Strategy 2015-2018 [↑](#footnote-ref-8)
9. Department of Treasury and Finance (DTF), 2010, *Cost Recovery Guidelines*, Melbourne [↑](#footnote-ref-9)
10. Department of Treasury and Finance (DTF), 2010, *Cost Recovery Guidelines*, Melbourne [↑](#footnote-ref-10)
11. Government of Victoria, 2014, *Victorian Guide to Regulation*, Department of Treasury and Finance, Melbourne. [↑](#footnote-ref-11)
12. Australian Institute of Health and Welfare, Hospital performance: adverse events treated in hospitals [↑](#footnote-ref-12)
13. Medical Journal of Australia, 2004, Ehsani, Jackson & Duckett [↑](#footnote-ref-13)
14. Medical Journal of Australia, 2004, Ehsani, Jackson & Duckett [↑](#footnote-ref-14)
15. Source: Reserve Bank of Australia Inflation Calculator [↑](#footnote-ref-15)
16. See appendix 1 [↑](#footnote-ref-16)
17. Establishing a Monetary Value for lives saved: Issues and Controversies, Dr Peter Ableson, 2007 [↑](#footnote-ref-17)
18. Source: Reserve Bank of Australia Inflation Calculator [↑](#footnote-ref-18)
19. Hughes RG (editor), 2008, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville (MD). Agency for Healthcare Research and Quality US. [↑](#footnote-ref-19)
20. PriceWaterhouseCoopers,2011, Evaluation of three Better Skills Best Care pilot projects, <http://www.health.vic.gov.au/workforce/reform/workforce.htm>, [↑](#footnote-ref-20)
21. Australian Council for Safety and Quality in Health Care, Open Disclosure Project: *When Things Go Wrong – an Open Approach to Adverse Events, Issues Paper*, 2001. [↑](#footnote-ref-21)
22. Healthcare Leadership & Management Report, *Quality Improvement to Guide the New Health System*, National Library of Medicine, General Collection, Vol. 9, no 3, March 2011. [↑](#footnote-ref-22)
23. Australian Medical Council, 2009, *Good Medical Practice: A Code for Doctors in Australia*. [↑](#footnote-ref-23)