11 Ambulance services

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘11A’ prefix (for example, table 11A.1) and are available from the website www.pc.gov.au/rogs/2017. |
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This chapter reports performance information for ambulance services.

All abbreviations used in this Report are available in a complete list in volume A: Approach to performance reporting.

## 11.1 Profile of ambulance services

### Service overview

Ambulance services include preparing for, providing and enhancing:

* emergency and non‑emergency pre‑hospital and out‑of‑hospital patient care and transport
* inter‑hospital patient transport including the movement of critical patients
* specialised rescue services
* the ambulance component of multi‑casualty events
* the community’s capacity to respond to emergencies.

### Roles and responsibilities

Ambulance service organisations are the primary agencies involved in providing services for ambulance events. State and Territory governments provide ambulance services in most jurisdictions. In WA and the NT, St John Ambulance is under contract to the respective governments as the primary provider of ambulance services (table 11A.1).

Across jurisdictions the role of ambulance service organisations serves as an integral part of the health system. The role of paramedics is expanding to include the assessment and management of patients with minor illnesses and injuries to avoid transport to hospital (Thompson et. al. 2014). In some rural and remote communities paramedics provide extended access to health service delivery.

In a limited number of cases, other organisations provide services such as medical transport for emergencies (Emergency management sector overview — table DA.1).

### Funding

Total expenditure on ambulance services was $3.0 billion in 2015‑16 (table 11A.16), which was funded from a mix of revenue sources. Total revenue of ambulance service organisations was $3.0 billion in 2015‑16, representing an annual average growth rate of 3.7 per cent since 2011-12 (table 11.1).

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| Table 11.1 Revenue of ambulance service organisations (2015‑16 dollars) ($ million)**a** |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust | | 2011-12 | 761.7 | 649.2 | 609.2 | 222.9 | 220.8 | 62.4 | 38.2 | 25.1 | 2 589.5 | | 2012-13 | 807.8 | 714.4 | 599.3 | 237.6 | 252.6 | 65.2 | 38.5 | 26.9 | 2 742.1 | | 2013-14 | 826.1 | 682.8 | 602.8 | 249.5 | 244.2 | 61.6 | 41.6 | 26.3 | 2 734.9 | | 2014-15 | 824.4 | 746.6 | 610.4 | 257.6 | 162.0 | 58.7 | 44.2 | 28.0 | 2 731.9 | | 2015-16 | 882.7 | 810.9 | 649.6 | 261.2 | 261.2 | 57.4 | 43.4 | 28.6 | 2 995.4 | |
| a See table 11A.2 for detailed footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); table 11A.2. |
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Jurisdictions have different funding models to provide resourcing to ambulance service organisations. Nationally in 2015‑16, State and Territory government grants and indirect government funding formed the greatest source of ambulance service organisations funding (70.1 per cent of total funding, and $87.67 per person), followed by transport fees (from public hospitals, private citizens and insurance (24.1 per cent of total funding, or $30.18 per person) (table 11A.18). Ambulance subscriptions are also a source of funding in some jurisdictions (table 11A.2).

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### Size and scope

#### Ambulance service organisation assets and air ambulance resources

Nationally in 2015‑16, ambulance service organisations operated 1520 response locations (1367 first responder locations with an ambulance) and 3599 ambulance general transport and patient transport vehicles (table 11A.9).

There are air ambulance (also called aero‑medical) services in all jurisdictions, although arrangements vary across jurisdictions. There were 94 air ambulance aircraft available nationally in 2015‑16 (table 11A.10).

#### Human resources

Nationally in 2015‑16, for ambulance services reported in this chapter there were:

* 16 087 FTE salaried personnel (80.6 per cent were ambulance operatives)
* 6182 volunteer personnel (97.3 per cent were ambulance operatives)
* 2620 ambulance community first responders. Community first responders are trained volunteers that provide an emergency response (with no transport capacity) and first aid care before ambulance arrival (table 11A.5).

#### Demand for ambulance services

Nationally in 2015‑16, there were:

* 3.4 million incidents — events that result in a demand for ambulance resources to respond — were reported to ambulance service organisations (145.1 incidents per 1000 people)
* 4.3 million responses — where an ambulance vehicle/s are sent to an incident (178.1 responses per 1000 people). There can be multiple responses sent to a single incident. There can also be responses to incidents that do not have people requiring treatment and/or transport
* 3.2 million patients assessed, treated or transported by ambulance service organisations (136.8 patients per 1000 people) — (figure 11.1 and table 11A.3).

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| Figure 11.1 Reported ambulance incidents, responses and patients,  per 1000 people, 2015‑16**a** |
| |  | | --- | | Figure 11.1 Reported ambulance incidents, responses and patients, per 1000 people, 2015-16  More details can be found within the text surrounding this image. | |
| a See table 11A.3 for detailed footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); table 11A.3. |
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Ambulance service organisations prioritise incidents as:

* emergency — immediate response under lights and sirens required (code 1)
* urgent — undelayed response required without lights and sirens (code 2)
* non‑emergency — non‑urgent response required (codes 3, 4)
* casualty room attendance.

Nationally in 2015‑16, 40.3 per cent of the 3.4 million incidents ambulance service organisations attended were prioritised as emergency incidents, followed by 33.9 per cent prioritised as urgent and 25.9 per cent prioritised as non-emergency (table 11A.3). There were 322 casualty room attendance incidents (all of which occurred in Queensland).

## 11.2 Framework of performance indicators

The performance indicator framework is based on governments’ common objectives for ambulance services (box 11.1).

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| Box 11.1 Objectives for ambulance services |
| Ambulance services aim to promote health and reduce the adverse effects of emergency events on the community. Governments’ involvement in ambulance services is aimed at providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are:   * accessible and timely * meet patients’ needs through delivery of appropriate health care * high quality — safe, co-ordinated and responsive health care * sustainable.   Governments aim for ambulance services to meet these objectives in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of ambulance services (figure 11.2).

The performance indicator framework shows which data are complete and comparable in the 2017 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report-wide perspective. In addition to section 11.1, the Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter (chapter 2).

Improvements to performance reporting for ambulance services are ongoing and will include identifying indicators to fill gaps in reporting against key objectives, improving the comparability and completeness of data and reviewing proxy indicators to establish whether more direct measures can be developed.

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| Figure 11.2 Ambulance services performance indicator framework |
| |  | | --- | | Figure 11.2 Ambulance services performance indicator framework  More details can be found within the text surrounding this image. | |
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## 11.3 Key performance indicator results

Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of ambulance services.

### Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1). Output information is also critical for equitable, efficient and effective management of government services.

### Equity

There are currently no identified indicators on equity of access to ambulance services for special needs groups.

### Effectiveness

#### Access — Response times

‘Response times’ is an indicator of governments’ objective of providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are accessible and timely (box 11.2).

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| Box 11.2 Response times |
| ‘Response times’ (illustrated below) is defined as the time taken between the initial receipt of the call for an emergency ambulance at the communications centre, and the arrival of the first responding ambulance resource at the scene of an emergency.  Figure in box 11.2 on process flow for response times from triple zero call through to clearance of case after arrival at medical centre  More details can be found within the text surrounding this image.  ‘Response times’ is defined by three measures:   * ‘Urban centre response times’ and ‘State-wide response times’ — defined as the time taken between the arrival of the first responding ambulance resource at the scene of an emergency code 1 incident, and the initial receipt of the call for an emergency ambulance at the communications centre (with separate measures for response times in urban centres and state-wide). * ‘Triple zero (000) call answering time’ — defined as the time interval commencing when the emergency call service has answered the triple zero (000) call and selected the desired emergency service organisation, to when the ambulance service organisation has answered the call. It is measured as the percentage of triple zero (000) calls that were answered by ambulance service communication centre staff in 10 seconds or less. |
| (continued next page) |
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| Box 11.2 (continued)  Response times are calculated for the 50th and 90th percentile — the time (in minutes) within which 50 per cent and 90 per cent of the first responding ambulance resources arrive at the scene of an emergency code 1 incident. Short or reducing response times suggests the adverse effects on patients and the community of emergencies requiring ambulance services are reduced. Differences across jurisdictions in the geography, personnel mix, and system type for capturing data, affect urban centre and state-wide response times data including:   * crewing configurations, response systems and processes, and travel distances — for example, some jurisdictions include responses from volunteer stations (often in rural areas) where turnout times are generally longer because volunteers are on call as distinct from being on duty * land area, and population size and density — for example, data calculated on a state-wide basis for some jurisdictions represent responses to urban, rural and remote areas, while others include urban centres only.   Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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##### Urban centre response times

In 2015‑16, the time within which 90 per cent of first responding ambulance resources arrived at the scene of an emergency in code 1 situations in capital cities ranged from  
13.7 to 29.4 minutes across jurisdictions (figure 11.3). The median (50th percentile) response times ranged from 8.3 to 11.9 minutes (table 11A.14).

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| Figure 11.3 Ambulance response times, capital city, 90th percentile**a** |
| |  | | --- | | Figure 11.3 Ambulance response times, capital city, 90th percentile  More details can be found within the text surrounding this image. | |
| a See box 11.2 and table 11A.14 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (2010) *Australian Statistical Geography Standard (ASGS): Volume 1 ‑ Main Structure and Greater Capital City Statistical Areas, July 2016*, Cat. no. 1270.0.55.001, Canberra; State and Territory governments (unpublished); table 11A.14. |
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##### State‑wide response times

In 2015‑16, the time within which 90 per cent of first responding ambulance resources arrived at the scene of an emergency in code 1 situations state-wide ranged from 13.7 to 27.3 minutes across jurisdictions (figure 11.4). The median (50th percentile) response times ranged from 8.4 to 12.9 minutes (table 11A.14).

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| Figure 11.4 Ambulance response times, state‑wide, 90th percentile**a** |
| |  | | --- | | Figure 11.4 Ambulance response times, state-wide, 90th percentile  More details can be found within the text surrounding this image. | |
| a See box 11.2 and table 11A.14 for detailed definitions, footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); table 11A.14. |
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##### Triple zero (000) call answering time

Nationally in 2015‑16, ambulance service organisations answered 93.2 per cent of calls from triple zero (000) in ten seconds or less (table 11A.15).

#### Appropriateness — Clinical — Pain management

‘Pain management’ is an indicator of governments’ objective of providing pre‑hospital and out‑of‑hospital care and patient transport services that meet patients’ needs through delivery of appropriate health care (box 11.3).

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| Box 11.3 Pain management |
| ‘Pain management’ is defined as the percentage of patients who report a clinically meaningful pain reduction. Clinically meaningful pain reduction is defined as a minimum 2 point reduction in pain score from first to final recorded measurement (based on a 1-10 numeric rating scale of pain intensity).  Includes patients who:   * are aged 16 years or over and received care from the ambulance service, which included the administration of pain medication (analgesia) * recorded at least 2 pain scores (pre‑ and post‑treatment) * recorded an initial pain score of 7 or above (referred to as severe pain).   Patients who refuse pain medication for whatever reason are excluded.  A higher or increasing percentage of patients with a clinically meaningful reduction in pain at the end of ambulance service treatment suggests improved patient outcomes.  Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions. |
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Nationally in 2015‑16, 87.9 per cent of patients who initially reported severe pain to an ambulance service, reported clinically meaningful pain reduction at the end of the service (figure 11.5).

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| --- |
| Figure 11.5 Patients who report a clinically meaningful pain reduction**a** |
| |  | | --- | | Figure 11.5 Patients who report a clinically meaningful pain reduction  More details can be found within the text surrounding this image. | |
| a See box 11.3 and table 11A.12 for detailed definitions, footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); table 11A.12. |
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#### Quality — Safety — Clinical incidents

‘Clinical incidents’ has been identified as an indicator of governments’ objective of providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are safe (box 11.4).

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| Box 11.4 Clinical incidents |
| ‘Clinical incidents’ are broadly defined as adverse events that occur because of ambulance service system failure, which result in death or serious harm to a patient.  Clinical incidents will incorporate a wider range of categories than the national core set of hospital sentinel events. Hospital sentinel events are adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient (chapter 12).  This indicator has been identified for development in accordance with national health‑wide reporting standards. |
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#### Quality — Responsiveness — Level of patient satisfaction

‘Level of patient satisfaction’ is an indicator of governments’ objective of providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are responsive to patients’ needs (box 11.5).

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| Box 11.5 Level of patient satisfaction |
| ‘Level of patient satisfaction’ is defined as the number of patients who were either ‘satisfied’ or ‘very satisfied’ with the ambulance services they had received in the previous 12 months, divided by the number of patients that had received a service in the previous 12 months.  Patients are defined as people who were transported under an emergency event classified as code 1 (an emergency event requiring one or more immediate ambulance responses under light and sirens where the incident is potentially life threatening) or code 2 (urgent incidents requiring an undelayed response by one or more ambulances without warning devices, with arrival desirable within thirty minutes).  A higher level or increase in the proportion of patients who were ‘satisfied’ or ‘very satisfied’ suggests greater success in meeting patient needs.  Data for these measures are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period. All required 2016 data are not available for NSW. |
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Nationally in 2016, 98 per cent of patients indicated that they were satisfied or very satisfied with the ambulance services received, with no significant differences across jurisdictions (this was also the case for the particular aspects of arrival time and treatment) (figure 11.6). Over ten years, the estimated satisfaction levels for ambulance patients were similar across all jurisdictions (table 11A.13).

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| Figure 11.6 Proportion of ambulance users who were satisfied or very satisfied with the ambulance service, 2016**a, b** |
| |  | | --- | | Figure 11.6 Proportion of ambulance users who were satisfied or very satisfied with the ambulance service, 2016  More details can be found within the text surrounding this image. | |
| a See box 11.5 and table 11A.13 for detailed definitions, footnotes and caveats. b NSW overall satisfaction data are not available. |
| *Source*: CAA 2015, *Council of Ambulance Authorities Patient Satisfaction Survey 2016*; table 11A.13. |
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#### Sustainability

Sustainability is the capacity to provide infrastructure (that is, workforce, facilities, and equipment) into the future, be innovative and respond to emerging needs of the community.

#### Sustainability — Ambulance workforce

‘Ambulance workforce’ is an indicator of governments’ objective of providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that are sustainable (box 11.6).

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| Box 11.6 Ambulance workforce |
| ‘Ambulance workforce’ is defined by two measures:   * ‘workforce by age group’ – the age profile of the salaried workforce, measured by the proportion of the operational salaried workforce in 10 year age brackets (under 30, 30–39, 40–49, 50–59 and 60 and over) * ‘attrition in the operational workforce’ – defined as the number of FTE salaried staff who exit the organisation as a proportion of the number of FTE salaried staff. Includes staff in operational positions where paramedic qualifications are either essential or desirable to the role.   A low or decreasing proportion of the workforce who are in the younger age groups and/or a high or increasing proportion who are closer to retirement suggests sustainability problems may arise in the coming decade as the older age group starts to retire. Low or decreasing levels of staff attrition are also desirable.  Data reported for these measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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The workforce by age group and staff attrition measures should be considered together. Each provides a different aspect of the changing profile and sustainability of ambulance service organisations’ workforces and should also be considered in conjunction with data on the:

* number of students enrolled in accredited paramedic training courses (table 11A.7)
* availability of paramedics and response locations, which show for some jurisdictions there can be a large proportion of volunteers or volunteer ambulance locations (tables 11A.5 and 11A.8).

##### Workforce by age group

Nationally in 2015‑16, 77.3 per cent of the ambulance workforce were aged under 50 years, a decrease from 81.0 per cent in 2008-09 (table 11A.6 and figure 11.7).

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| Figure 11.7 Operational workforce under 50 years**a** |
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| | Figure 11.7 Operational workforce under 50 years  More details can be found within the text surrounding this image. | | --- | |
| a See table 11A.6 for detailed footnotes and caveats. |
| *Source*: State and Territory governments (unpublished), table 11A.6. |
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##### Staff attrition

Nationally, the staff attrition rate was 3.3 per cent in 2015‑16, which varied across jurisdictions (figure 11.8).

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| Figure 11.8 Attrition in the operational workforce**a, b** |
| |  | | --- | | Figure 11.8 Attrition in the operational workforce  More details can be found within the text surrounding this image. | |
| a See box 11.6 and table 11A.6 for detailed definitions, footnotes and caveats. b Data not available for NT for 2014-15, and nil or rounded to zero for 2013-14, and 2011-12. |
| *Source*: State and Territory governments (unpublished), table 11A.6. |
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### Efficiency

#### Ambulance services expenditure per person

‘Ambulance service expenditure per person’ is a proxy indicator of governments’ objective of providing emergency medical care, pre-hospital and out-of-hospital care, and transport services in an efficient manner (box 11.7).

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| Box 11.7 Ambulance services expenditure per person |
| ‘Ambulance service organisations’ expenditure per person’ is defined as total ambulance service organisation expenditure per person in the population.  Both the total cost of ambulance service organisations and the cost to government of funding ambulance service organisations are reported, because revenue from transport fees is significant for a number of jurisdictions.  All else being equal, lower expenditure per person represents greater efficiency. However, efficiency data should be interpreted with caution.   * High or increasing expenditure per person may reflect deteriorating efficiency. Alternatively, it may reflect changes in: aspects of the service (such as improved response); resourcing for first aid and community safety; or the characteristics of events requiring ambulance service response (such as more serious para‑medical challenges) * Differences in geographic size, terrain, climate, and population dispersal may affect costs of infrastructure and numbers of service delivery locations per person.   Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Nationally, total expenditure on ambulance service organisations was $126.40 per person in 2015‑16 (table 11A.17 and figure 11.9). Service delivery strategies vary across jurisdictions (e.g., mix of servicing across locations by paid and volunteer staff) which impacts on expenditure per person.

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| Figure 11.9 Expenditure per person (2015‑16 dollars)a |
| |  | | --- | | Figure 11.9 Expenditure per person in 2015-16 dollars  More details can be found within the text surrounding this image. | |
| a See box 11.7 and table 11A.17 for detailed definitions, footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); tables 11A.17. |
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### Outcomes

Outcomes are the impact services on an individual or group (see chapter 1).

#### Cardiac arrest survived event rate

‘Cardiac arrest survived event rate’ is an indicator of governments’ objective providing emergency medical care, pre-hospital and out-of-hospital care, and transport services that reduce the adverse effects of emergency events on the community (box 11.8).

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| Box 11.8 Cardiac arrest survived event |
| ‘Cardiac arrest survived event rate’ is defined as the proportion of patients aged 16 years or over who were in out‑of‑hospital cardiac arrest and had a return to spontaneous circulation (that is, the patient having a pulse) until administration and transfer of care to the medical staff at the receiving hospital (Jacobs et al. 2004).  Three separate measures are provided:   * Adult cardiac arrest where resuscitation attempted, where: * a person was in out‑of‑hospital cardiac arrest (which was not witnessed by a paramedic) * chest compressions and/or defibrillation was undertaken by ambulance or emergency medical services personnel. * Adult Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT) cardiac arrests[[1]](#footnote-1) where: * a person was in out‑of‑hospital cardiac arrest (which was not witnessed by a paramedic) * the arrest rhythm on the first ECG assessment was either VF or VT * Paramedic witnessed cardiac arrest — where a person was in out‑of‑hospital cardiac arrest that occurred in the presence of an ambulance paramedic or officer.   A high or increasing cardiac arrest survived event rate is desirable.  Data reported for these measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2015‑16 data are available for all jurisdictions. |
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Across jurisdictions, the survival rate for patients in VF or VT cardiac arrest are higher than for other adult cardiac arrests (figure 11.10 and table 11A.11). VF or VT are electrical rhythms of the heart but are not associated with effective beating of the heart to produce a pulse. Patients that suffer a VF/VT cardiac arrest are more likely to have better outcomes compared with other causes of cardiac arrest as these conditions are primarily correctable through defibrillation, and the earlier this intervention is applied (either by ambulance or by a member of the community through the use of Automated External Defibrillators), the greater the chance of survival.

The survival rate from paramedic witnessed out‑of‑hospital cardiac arrests is higher than for other adult out‑of‑hospital cardiac arrests (excluding VF/VT cardiac arrests). Cardiac arrests that are treated immediately by the paramedic have a better likelihood of survival due to immediate and rapid intervention (figure 11.10).

| Figure 11.10 Cardiac arrest survived event rate, 2015-16**a** |
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| | Figure 11.10 Cardiac arrest survived event rate, 2015-16  More details can be found within the text surrounding this image. | | --- | |
| a See box 11.8 and table 11A.11 for detailed definitions, footnotes and caveats. |
| *Source*: State and Territory governments (unpublished); table 11A.11. |
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## 11.4 Definitions of key terms

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| **Expenditure** | Includes:   * salaries and payments in the nature of salaries to ambulance personnel * capital expenditure (such as the user cost of capital) * other operating expenditure (such as running expenditure, contract expenditure, training expenditure, maintenance expenditure, communications expenditure, provision for losses and other recurrent expenditure).   Excludes interest on borrowings. | |
| User cost  of capital | The opportunity cost of funds tied up in the capital used to deliver services. Calculated as 8 per cent of the current value of non‑current physical assets (including land, plant and equipment). | |
| **Human resources** | Human resources refers to any person delivering a service, or managing the delivery of this service, including:   * salaried ambulance personnel, remunerated volunteer and non‑remunerated volunteer ambulance personnel * support personnel (any paid person or volunteer directly supporting operational providers, including administrative, technical and communications personnel). | |
| **Revenue** | Revenue received directly or indirectly by ambulance service organisations on an accrual accounting basis, including: | |
| Government grant funding | Grant funding, as established in legislation, from the Australian, State/Territory and Local governments. | |
| Levies | Revenue from levies, as established in enabling legislation, raised on insurance companies and property owners. | |
| User/transport charges | Revenue from fees and charges on individuals, private/public organisations and insurers. | |
| Subscriptions and other income | Other revenue, including:   * subscriptions and benefit funds received from the community * donations, industry contributions and fundraising received * other income. | |
| Indirect revenue | All revenue or funding received indirectly by the agency (for example, directly to Treasury or other such entity) that arises from the agency’s actions. | |
| **Volunteer personnel** | |  |
| Volunteer ambulance operatives | All personnel engaged on an unpaid casual basis who are principally involved in the delivery of ambulance services, generally on an on‑call basis. These staff may include categories on the same basis as permanent ambulance operatives (with transport capability). | |
| Remunerated volunteer ambulance operatives | All personnel who volunteer their availability, however, are remunerated in part for provision of an ambulance response (with transport capability). | |
| Volunteer support staff | All personnel engaged on an unpaid casual basis that are not remunerated and are principally involved in the provision of support services. These can be people in operational support roles provided they do not receive payment for their services other than reimbursement of ‘out of pocket expenses’. | |

## 11.5 References

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Jacobs I, et al 2004, AHA Scientific Statement, *Cardiac Arrest and Cardiopulmonary Resuscitation Outcome Reports*, Update of the Utstein Templates for Resuscitation Registries, A Statement for Healthcare Professionals from a Task Force of the International Liaison Committee on Resuscitation (American Heart Association, European Resuscitation Council, Australian Resuscitation Council, New Zealand Resuscitation Council, Heart and Stroke Foundation of Canada, Inter American Heart Foundation, Resuscitation Councils of South Africa), circulation 23 November 2004, 110(21)c pp. 3385–97.

Thompson C, Williams K, Morris D, Lago L, Kobel C, Quinsey K, Eckermann S, Andersen P and Masso M 2014, *HWA Expanded Scopes of Practice Program Evaluation: Extending the Role of Paramedics Sub‑Project Final Report*. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

1. Ventricular Fibrillation (VF) is a heart rhythm problem that occurs when the heart beats with rapid, erratic electrical impulses. Ventricular Tachycardia (VT) is a type of regular and fast heart beat that arises from improper electrical activity in the ventricles of the heart. [↑](#footnote-ref-1)