Why Canada needs advanced practice roles - and why paramedics are the right place to start

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Introduction

Canada's system pressures are no longer "seasonal." Access gaps, widening inequities, workforce strain, and unsafe congestion in urgent and emergency pathways have become structural. This reality forces a more fundamental question than *"How many clinicians do we have?"*. Instead, we need to ask *"Are we designing roles so the workforce can meet population needs at scale?".* One of the most practical, evidence-informed answers is the deliberate expansion of advanced practice roles across professions. Paramedics are a compelling Canadian case because they're already distributed across geographies, operate with high autonomy, and work at the intersection where health care, social need, public health, and system navigation collide. But the real argument is bigger than paramedicine: advanced practice roles are a lever to advance equity of access, quality and safety standards, workforce retention, and a policy-literate leadership pipeline.

Paramedicine's evolution in Canada has been mirrored by a deliberate effort to modernize how the profession defines competence. The National Competency Framework for Paramedics (NCFP) was developed to reflect contemporary paramedic practice and its expanding contexts, organizing professional activities across five domains and multiple practice settings.[1] This matters because advanced roles fail when they're built as ad-hoc pilots or treated as exceptions to the rule; they succeed when role design is anchored to clear professional expectations, governance, and system fit.[2]

Reasons to act

Equity of access is the clearest reason to act. In a country where distance, income, housing stability, and access to primary care still predict whether someone receives timely care, paramedics are uniquely positioned to deliver care where people are at home, in community settings, and in the moments when conventional services are least reachable.[3,4] Community paramedicine is explicitly designed to fill service gaps for underserved populations and reduce avoidable escalation.[5] It optimizes access to care by serving patients in rural and remote areas, after hours, and in a timely manner for urgent issues. What elevates this to more than a well-intentioned idea is that the NCFP explicitly grapples with contemporary concepts that shape equity and system readiness such as inclusion, diversity, equity and accessibility, anti-racism, social responsiveness, and virtual care in the context of complex adaptive systems.[1,6] The value-proposition of these concepts is simple: the workforce must be competent to deliver safe, appropriate care across different communities. This requires them to adapt to different settings and address different barriers to access.

Quality and safety are often raised as objections to expanded scopes. Yet the more realistic risk is the opposite: maintaining outdated roles in a system that has already started to demand more. This leads to informal scope stretches and workarounds, while relying on the good will of individual providers to make the system function. Expanded roles improve safety when they are embedded inside clear competency expectations and clinical governance frameworks.[2] Our systems-thinking work to map the "system of practice" underpinning Canadian paramedicine is essentially an argument for this embedding: you cannot build a modern competency framework (or modern advanced practice roles) if you don't first understand the systemic contexts, influences, and realities of practice that shape clinician decision-making.[7] In other words, safe scope expansion isn't about doing "more tasks." It's about doing the right work, in the right places, with the right supports, whilst being explicit about what competence looks like in those settings.[2]

Retention is the next pressure point, and it's where advanced practice roles can deliver rapid, tangible system benefit. Canada's health workforce challenges (particularly in paramedicine) are not just pipeline problems; they are also career design and longevity problems. When experienced clinicians see no progression other than leaving patient care or leaving the profession, attrition becomes rational. The Career Framework for Paramedics (2024) is a direct response to that issue, outlining five career pathways: clinical practice, organizational leadership, research, education, and policy & strategy.[8] The framework links the profession's future sustainability to credible progression and education preparation aligned with the NCFP. This aims to change the retention discussion by legitimizing growth inside the profession, rather than forcing exit from the profession to pursue more advanced capability.

Advanced practice roles also do something the system desperately needs; they foster growth to understand policy, governance, and program design. The Career Framework is unusually explicit that paramedicine in Canada has been under-represented in senior system decision-making and that future readiness requires clearer pathways into leadership and policy roles.[9] If you want leaders who can reform interdisciplinary practice, you have to build roles that move beyond exposure to pathway failures and towards embedded system responsibilities. While clinicians at all levels experience transitions, bottlenecks, inequities, and preventable escalation, advanced practice roles uniquely position providers to engage directly in improving these issues through leadership, research, education and policy. With the right education and governance to support such roles, this evolves into enhanced system capacity.

Insights from the UK and Ireland

The UK example shows both the promise and the "how" of implementation. Over the past decade, paramedics have increasingly been integrated into general practice and primary care teams in the UK, supporting same-day access, home visits, and assessment of undifferentiated presentations.[10] A realist synthesis of paramedics in general practice highlights that benefits depend on role clarity, appropriate education, governance, and team integration; where those conditions are met, paramedics can expand capacity and improve access, while complementing (not replacing) GP care.[11] The UK experience is useful for Canada because it demonstrates that successful expansion is not just a scope decision; it's an implementation decision about training, governance, and the development of shared

mental models of the intended goals of such roles. The Republic of Ireland is now exploring similar roles, and the same core issues of education, governance, and integration are being carefully and deliberately explored to ensure success.[12–15]

Next steps for Canada

So, what should Canadian decision-makers do if they accept the case? First, stop treating advanced practice paramedic roles as isolated pilots and start treating them as complexity-responsive and outcome-oriented programs, whereby a pilot is only one component. This involves starting with predefined outcomes and utilizing systems analysis to map the complexity of dimensions, such as stakeholder interactions, thereby ensuring the design accounts for multiple nonlinear factors that influence real-world results. Using existing national frameworks as anchors will support this method: the NCFP as the baseline description of contemporary practice, the emerging concepts literature as a signal of what "future-ready competence" must include, and the Career Framework as the retention and leadership scaffolding that makes expansion sustainable.

Second, align regulation, funding, and measurement with outcomes that matter.[16] If expanded roles are judged only by operational response times or ED non-conveyance rates, this will distract from their core intent. If they're judged by avoidable emergency department use, continuity of care, patient-reported outcomes, reduced adverse events, and improved equity of access, they start to look like roles that bolster access to care, improve patient outcomes, augment the experience of care, and increase capacity in the system.

Third, invest in education pathways that are compatible with the increased responsibilities of these roles. The Career Framework explicitly links the NCFP and supporting documents to higher education preparation, assessment, accreditation, and advanced practice roles. If Canada wants a workforce that can safely deliver more care in more settings, we must prepare it that way, and credential it that way.[17,18] Canada does not need scope expansion for paramedics as a political gesture. It requires advanced practice roles as part of a disciplined, whole-of-system strategy. Paramedics show the pathway clearly: define contemporary competence and standards, design roles that fit contemporary patient needs, govern them well, and build career pathways that retain and grow people into the leaders the system will require.

What this means for Canada right now

If advanced practice roles are to move beyond pilots and policy rhetoric, governments and health system leaders in Canada need to act decisively. The following three moves are achievable now within existing structures and would materially advance access, quality, workforce stability, and leadership capacity.

1. Anchor expanded roles to existing national frameworks

Canada already has the foundations it needs. The NCFP and the Career Framework provide a coherent description of contemporary paramedic practice, emerging system demands, and credible career progression. Rather than creating bespoke role descriptions for every pilot, provinces and employers should explicitly align advanced practice roles to these national

frameworks. This does three things at once. It clarifies expectations for safe and competent practice, it creates consistency across jurisdictions, and it legitimizes advanced roles as part of the profession's core identity rather than as temporary exceptions. For regulators, this alignment reduces risk. For educators, it provides direction. For clinicians, it signals that expanded roles are recognized, portable, and worth their investment.

2. Fund outcomes, not job titles

One of the most persistent barriers to expanded paramedic roles is misaligned funding. When services are funded primarily on operational KPIs such as response times or conveyance metrics, any role that prevents conveyance or resolves care in the community can appear financially "inefficient," even when it improves system performance. Policymakers can address this by funding advanced practice roles against outcomes that matter to patients and systems: avoided emergency department visits, continuity of care, reduced time to assessment, patient-reported experience, and equity of access for underserved populations.[16] This does not require new funding so much as smarter investing. Jurisdictions that pay for outcomes create the conditions for paramedics and other professions to work at the top of their capability without being penalized for doing the right thing.

3. Build leadership and policy capability into advanced practice

Expanded clinical roles should not be the ceiling of workforce ambition; they should be the gateway to system leadership. The Career Framework explicitly identifies leadership, research, education, and policy as career pathways alongside clinical practice. Governments and employers should reinforce this by embedding leadership development, quality improvement, and policy literacy into advanced practice roles. This can include protected time for system improvement work, formal leadership education linked to advanced roles, and structured pathways into regional or provincial planning tables. The return on investment is significant: clinicians who understand how policy decisions affect care delivery are uniquely positioned to lead reforms that are both bold and pragmatic.

Taken together, these three moves shift advanced practice roles from bespoke, innovative (and often time-limited) projects to core infrastructure. They align competence, funding, and leadership in a way that supports equity of access, patient safety, workforce sustainability, and a health system capable of adapting to complexity and future demands.

Authors

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References

1. Batt AM, Bolster JL, Lysko M, et al. Representing contemporary paramedic practice in Canada: Development of the national competency framework for paramedics. *Paramedicine* 2025; 22: 111–126.

2. Batt A, Leduc S, Bolster J. *Scope is not the problem: why governance is the real risk for advanced practice by paramedics in Canada – policy commentary*. Zenodo.

3. Ashton C, Leyenaar MS. *Health Service Needs in the North: A Case Study on CSA Standard for Community Paramedicine*. Canada: Canadian Standards Association, 2019.

4. Ashton C. *Health in the North: The Potential for Community Paramedicine in Remote and/or Isolated Indigenous Communities*. Toronto: CSA Group.

5. O'Meara P, Stirling C, Ruest M, et al. Community paramedicine model of care: an observational, ethnographic case study. *BMC health services research* 2016; 16: 39–39.

6. Bolster J, Pithia P, Batt AM. Emerging Concepts in the Paramedicine Literature to Inform the Revision of a Pan-Canadian Competency Framework for Paramedics: A Restricted Review. *Cureus* 2022; 14: 32864.

7. Batt AM, Lysko M, Bolster JL, et al. Identifying Features of a System of Practice to Inform a Contemporary Competency Framework for Paramedics in Canada. *Healthcare* 2024; 12: 946.

8. Cameron C, Batt AM. *Career Framework for Paramedics*. Ottawa: Paramedic Association of Canada, 2024.

9. Bolster JL, Batt AM. Building bridges and moving upstream: Paramedics as policy architects. *Paramedicine* 2025; 27536386251336008.

10. Eaton G, Wong G, Williams V, et al. Contribution of paramedics in primary and urgent care: a systematic review. *British Journal of General Practice* 2020; 70: e421–e426.

11. Stott H, Goodenough T, Jagosh J, et al. Understanding paramedic work in general practice in the UK: a rapid realist synthesis. *BMC Prim Care* 2024; 25: 32.

12. Barry T, Batt A, Agarwal G, et al. Potential for Paramedic roles in Irish General Practice: A qualitative study of stakeholder's perspectives. *HRB Open Research*; 5. Epub ahead of print 23 May 2022. DOI: 10.12688/hrbopenres.13545.1.

13. Cunningham C, Masterson S, Batt A, et al. Developing A Complex Intervention to Integrate Community Paramedics in GP Out-of-Hours Care in Ireland: A Qualitative Study. *HRB Open Res* 2026; 9: 6.

14. Feerick F, Armstrong C, O'Connor R, et al. Is There A Role For Paramedics In Primary Care In Ireland: An Exploratory Study. *Irish Journal of Paramedicine*; 3. Epub ahead of print 2 October 2018. DOI: 10.32378/ijp.v3i2.133.

15. Feerick F, Connor CO, Hayes P, et al. Introducing Advanced Paramedics into the rural general practice team in Ireland – general practitioners attitudes. *BMC Prim Care* 2022; 23: 130.

16. Eastwood K, Batt A, Tavares W. The importance of outcome measures that matter in paramedicine research. *Paramedicine* 2025; 22: 1–5.

17. O'Meara P, Furness S, Gleeson R. Educating paramedics for the future: a holistic approach. *Journal of Health and Human Services Administration* 2017; 40: 219–253.

18. O'Meara P, Ruest M, Stirling C. Community paramedicine: Higher education as an enabling factor. *Australasian Journal of Paramedicine* 2014; 11: 5.