

Unleashing the Potential of our Health Workforce

Scope of Practice Review

Issues Paper 1

23 January 2024

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Acknowledgements

The Scope of Practice Review team acknowledges the Traditional Owners of Country throughout Australia. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country. We recognise their contributions to Australian and global society.

Glossary

Accreditation	Refers to a formal process of approval for a program of study or training that provides a person who completes that program or training with the knowledge, skills and professional attributes needed to practice their health profession or undertake that activity.
Acute care	Care in which the intent is to perform surgery, diagnostic or therapeutic procedures in the treatment of illness or injury. Management of childbirth is also considered acute care.
Collaborative practice (multidisciplinary or team-based care)	Collaborative practice in health care occurs when multiple health professionals from different professional backgrounds provide comprehensive services by working with each other, and with patients, their families, carers and communities to deliver the highest quality of care across settings. ¹ For example, care provided by multidisciplinary care teams.
Continuity of care	Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.
Credentiailling	A formal process used to verify the qualifications and experience of health professionals within a specific health care setting and role, used predominantly in the acute health system.
Endorsement	Recognition by National Boards that a person has additional qualifications and expertise in an approved area of practice and/or for scheduled medicine.
Fee-for-service funding	The main payment model for primary health care in Australia, in which health care providers are paid per episode of care delivered by a specified type of health professional.
Full scope of practice	Professional activities that a practitioner is educated (skill / knowledge), competent and authorised to perform, and for which they are accountable. Individual scope is time-sensitive and dynamic. Scope of practice for individual practitioners is influenced by the settings in which they practice, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority / governance) of the service provider.

¹ World Health Organization. Framework for action on interprofessional education and collaborative practice. Accessed from: <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>.

GP-centred primary health care model	Refers to the central role that general practitioners play in primary care by facilitating referrals to care provided by other health professionals or service providers.
Primary health care	Primary health care is health care people seek first in their community, such as GPs, pharmacies and allied health professionals. Generally, this is health care outside of a hospital or specialist. ²

Acronyms

ACCHO	Aboriginal Community Controlled Health Organisations
Ahpra	Australian Health Practitioner Regulation Agency
EBA	Enterprise Bargaining Agreement
FHT	Family Health Team
GP	General Practitioner
IRL	Independent Review Lead
MBS	Medicare Benefits Schedule
NIPVIP	National Immunisation Program Vaccinations in Pharmacy
NRAS	National Registration and Accreditation Scheme
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network

² Australian Government Department of Health and Aged Care. Primary Care. Accessed from: <https://www.health.gov.au/topics/primary-care#:~:text=Primary%20care%20is%20health%20care,pharmacies%20and%20allied%20health%20professionals.>

Executive Summary

This Issues Paper has been developed as part of the Unleashing the Potential of our Health Workforce – Scope of Practice Review ('the Review'). This independent Review focuses on health professionals who currently provide or have the potential to provide primary care, and explores the available evidence of the benefits, risks, barriers and enablers associated with health practitioners working to their full scope of practice. Full scope of practice means the professional activities that a practitioner is educated (skill/knowledge), competent and authorised to perform, and for which they are accountable.

A process of literature review and stakeholder consultation and analysis has been undertaken to date to collect evidence to support the Review. The purpose of this Issues Paper is to provide an overview of the evidence collected to date, outline the emerging themes from this evidence, and describe the direction and next steps for this Review.

This is the first Issues Paper of two to be developed through this Review. This Issues Paper will directly inform upcoming consultation during Phase 2 of the Review and into the Final Report.

Five key themes emerged from a synthesis of evidence to date and are explored within this Issues Paper. Key findings for each of these emerging themes are presented below.

Legislation and regulation: legislation or regulation may authorise or inhibit health professionals in performing a particular activity. Evidence to date revealed inconsistencies in the regulatory approaches across primary health care professions, and barriers relating to inconsistent State and Territory legislation and the practice of named professions in specific pieces of legislation or regulation. Greater harmonisation of legislation and a more risk-based approach to regulation are among the potential policy solutions for further exploration.

Employer practices and settings: practices and settings at the individual service level which influence health professionals' ability to work to full scope of practice, including role design and employment models. Evidence to date emphasised the inherent challenges in progressing scope of practice reform over a dispersed primary health care sector in which individual employers hold significant influence over health professionals' authority to practice individually and as multidisciplinary care teams. Targeting leadership and culture to promote enabling and authorising environments at the service level emerged as a critical complement to other system-level reform.

Education and training: pre- and post-professional entry learning and qualifications, including opportunities for professional development, mentoring, supervision and upskilling, and interprofessional learning. Unclear and inconsistent requirements were highlighted through evidence to date, particularly relating to post-professional entry skills, specialities and endorsements. There are further opportunities for common interprofessional competencies to be developed.

Funding policy: the way funding and payment is made for delivery of health care. Evidence to date highlighted opportunities to better enable connected and multidisciplinary care across professions, through alternatives to the existing fee-for-service model (for example, block or bundled funding).

Technology: integrated and accessible digital tools, communication and information sharing. Acknowledging this as a key policy direction for the broader health system, the evidence indicated significant barriers relating to health information sharing and digital infrastructure, which if resolved could significantly support continuity of care and multidisciplinary care teams.

Across all emerging themes, a number of common potential benefits emerged including:

- **Improved consumer access to care and continuity of care**, minimising delays and cost of receiving care.
- **Improved multidisciplinary practice, interprofessional collaboration and trust** as the primary health care system supports enabling environments for collaborative care delivery and overlapping scopes of practice.
- **Improved consumer outcomes**, as primary health care is delivered in a more multidisciplinary way, tailored to the consumer's individual needs.
- **Improved workforce satisfaction and retention**, as health professionals are enabled to work to their full scope of practice.

The document is divided into four sections:

1. **Background and purpose** – presents the context for the Review, overview of approach to date, and purpose of this document.
2. **Summary of evidence** – provides an overview of key findings to date through evidence and introduces the five emerging themes.
3. **Emerging themes from analysis** – provides detail for each of the five emerging themes, including the key policy problems, potential policy solutions for ongoing exploration, case studies and exemplars, and a series of questions to support further consultation during Phase 2 of the Review.
4. **Next steps** – presents an overview of upcoming consultation during Phase 2 of the Review and the process for developing Issues Paper 2 and Final Report.

Background and purpose

The Strengthening Medicare Taskforce began work in July 2022 to provide concrete recommendations to the Australian Government by the end of 2022 in relation to:

- improving patient access to general practice, including after hours;
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health;
- making primary care more affordable for patients;
- improving prevention and management of ongoing and chronic conditions;
- reducing pressure on hospitals.

In December 2022, the Strengthening Medicare Taskforce Report outlined priority recommendations to improve primary care, including a review of barriers and incentives for all health practitioners to work to their full scope of practice. In April 2023, National Cabinet, which includes the Prime Minister and the First Minister from each state and territory, supported the Taskforce recommendations. As a result, the Australian Government provided funding to conduct a scope of practice review focussing on primary care in the 2023-2024 Budget, which commenced in September 2023.

Professor Mark Cormack is leading this intensive, independent Review. The Review focuses on key health professionals who currently provide or have the potential to provide primary care, and explores the available evidence of the benefits, risks and enablers associated with health practitioners working to their full scope of practice.

The Review will capture a broad range of perspectives through multiple opportunities for consultation. This will ensure the Review findings and recommendations are comprehensive and well-informed by health system stakeholders.

Phase 1 of the Review consultation was undertaken in September-December 2023. More than 700 submissions to targeted questions on scope of practice were received, and meetings held with over 90 organisations from across the health system. Insights shared by these groups explored current barriers to health professionals working to full scope of practice and how these barriers could be overcome to provide improved access to quality primary health care services for all Australians. This Issues Paper draws from the initial themes that have emerged from the Phase 1 consultation.

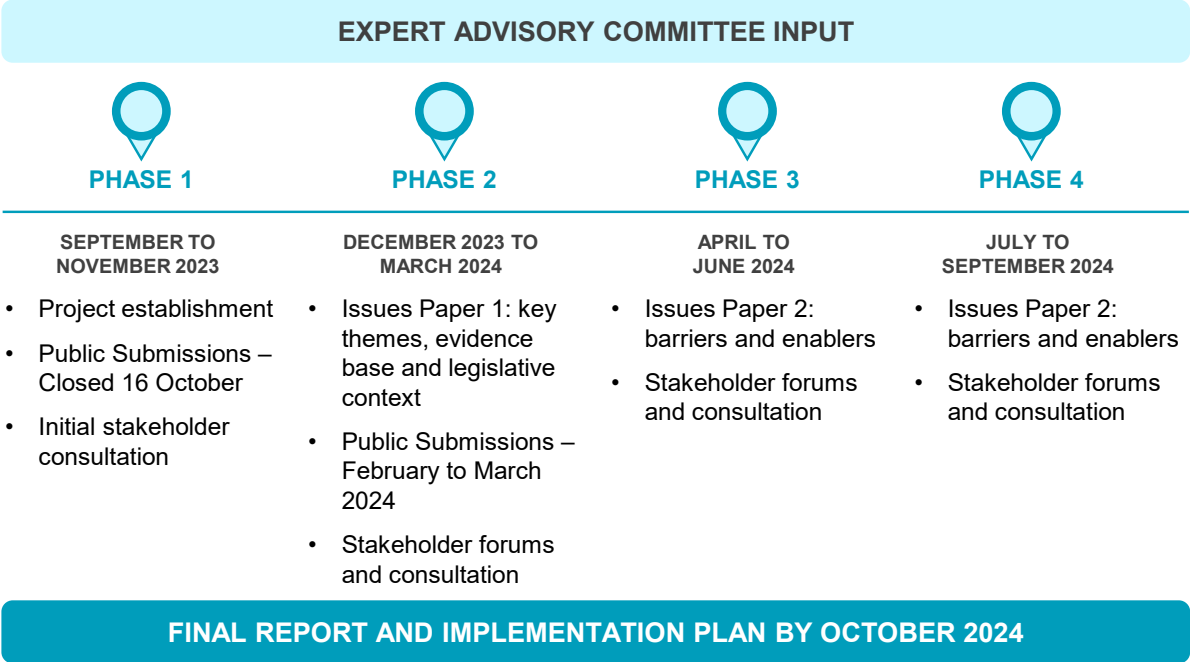
Phase 2 of Review consultations will be undertaken from January-March 2024. It will enable feedback from various perspectives on the emerging themes raised in this Issues Paper. Consultations will occur via a public submissions portal, face-to-face workshops across Australia and targeted stakeholder meetings. Consultations will be informed by questions raised throughout this Issues Paper. Phase 2 consultation feedback will be synthesised with other evidence to produce Issues Paper 2, which will explore the specific policy and system reforms available to address identified barriers associated with health professionals working to full scope of practice.

Phase 3 of the Review consultations will be undertaken from April-June 2024, to provide stakeholder insights on the content from Issues Paper 2 and inform the summation of findings into a draft Final Report to Government.

During **Phase 4** of the Review, from July to September 2024, a draft Final Report and Implementation Plan will be developed, drawing together all evidence received through previous consultations, Issues Papers and literature review. A final phase of public consultation on this report will be undertaken from July-September 2024. The final Review Report will be prepared and submitted to the Minister for Health and Aged Care by end of October 2024.

An **Expert Advisory Committee (EAC)** has also been convened to provide subject matter expertise, insights and advice throughout the Review. The EAC met for the first time in November and December 2023, and will meet in each Review Phase. This committee includes representatives from many areas of the health workforce, education and training sector, academia and consumers. Each member provides a wealth of experience, knowledge, skills and perspectives in the area of innovative and multidisciplinary primary health care for consumers.

Figure 1: How stakeholders can be involved throughout the Review



The purpose of this Issues Paper is to provide an overview of the evidence collected to date through literature review, submissions and consultations, outline the emerging themes from this evidence that require further exploration through the next phase of consultations, and describe the direction and next steps for this Review.

This document provides:

- a concise summary of evidence gathered to date;
- a summary of the emerging themes based on consultation to date;
- discussion questions to guide Phase 2 consultations.

Summary of evidence

This section summarises the key evidence drawn to date from a range of sources including analysis of the Phase 1 consultation findings and a review of the literature.

The literature review examined relevant academic journal articles, grey literature and international policy and practice examples. Literature was considered for in-scope primary care professions (Aboriginal and Torres Strait Islander Health Practitioners/Health Workers, allied health, medical, midwifery, nursing, paramedics and pharmacy) from Australia, New Zealand, Canada, United States of America, United Kingdom and Western Europe.

Broadly, the review of the evidence supports two key findings:

- Enabling health professionals to work to full scope of practice supports a stronger primary health care system;
- A range of barriers are currently preventing the primary health care workforce from working at full scope of practice.

Overview of evidence

The purpose of the literature review was to examine the evidence supporting (or not supporting) the value of health professionals working to their full scope of practice in the primary care setting. This included determining the current status of full scope of practice by major professional groups in Australia, best practice international examples and the barriers, risks, enablers and benefits to full scope of practice.

While the greatest volume of literature related to scope of practice came from nursing, midwifery, pharmacy and medical professionals, all of the key allied health professions were identified. In all groups a focus on patient outcomes, health service delivery and system implications were considered. The majority of relevant material for professions in the literature came from the United States, followed by Australia, New Zealand, Canada and the UK. Policy and practice examples from the UK and Canada were also found to be highly relevant to the Australian context.

The purpose of the Phase 1 consultations was to complement this literature evidence to understand the experience and perspective of Australian stakeholders on the status of scope of practice of health professionals in primary care. Respondents provided insights into who could benefit, risks, barriers and enablers through a series of targeted questions. A large volume of best practice examples was also submitted by stakeholders and consolidated as part of the literature review.

Key findings

Scope of practice reforms are considered valuable to enable the whole health workforce to be utilised effectively. Previous reforms identified in literature and international case examples have helped to address challenges in access to care and health system efficiency, related to maldistribution of health professionals in regional and remote areas or inequities in access related to socioeconomic status, culture or other social determinants of health. Consultation respondents agreed that scope of practice reform in Australia would also bring benefits for improved multidisciplinary health team functioning and consumer experience.

Inconsistent policy and regulatory frameworks have significant impact on the scope of practice of health professionals between locations (i.e., between states) and practice environments (i.e., between acute and primary care, or between different practices). This restricts the treatments that can be performed, access to funding for providing such treatments, or the level of autonomy to determine that these treatments are required. Consultation respondents also identified this barrier, noting the importance of consistency in terminology, competencies, education and practice expectations around scope of practice. Respondents expressed frustration that this barrier results in compromised care and highly skilled professionals leaving their roles.

Access to funding for treatments influences the scope of practice that health professionals are enabled to perform. The broader funding model, such as fee-for-service, can also reward procedural care over preventative and comprehensive, team-based care. Lower reimbursement rates in primary care settings compared with other specialties can also worsen health workforce shortages by encouraging professionals to leave or not choose to work in primary care. Reforms to address these challenges may incentivise comprehensive team-based care or improve workforce retention by increased staff satisfaction. The challenge is to balance this in an environment where overall funding is limited and without creating inefficiencies or added complexity.

Interprofessional collaboration and communication is crucial for providing team-based care that optimises outcomes for consumers. Identified barriers to this include communication challenges, traditional professional hierarchies, perceived scope overlap or role threat, and resistance based on poor understanding of each other's roles. In other countries, these barriers have been tackled through digital enablement, evidence-based reorganisation and funding of collaborative care teams, and enhanced professional awareness of team roles, explored in greater depth in the following section, [Emerging themes from analysis](#). This has led to innovative models of care that are well accepted by health professionals and consumers, and improved health outcomes. Consultation respondents often identified these innovative models from other countries or local practice examples, particularly in regional and remote areas to overcome workforce shortages.

The poor understanding of various health professional roles and/or trust in competency occurs amongst both health professionals and administrators. This can lead to a culture of resistance amongst policymakers to acknowledge, support and fund health professional activities at full scope of practice. To overcome this resistance requires clear evidence of improved outcomes when all health professionals are able to contribute fully to the health care team, education and advocacy. Consultation respondents also encouraged wider recognition of existing clinical and professional governance structures that are effective.

Conclusions

The literature review provided strong evidence of improved consumer access to care, consumer experience of care and health outcomes when health professionals are enabled to work to full scope of practice. Health professionals working to full scope of practice reduces workload for the acute care sector, increases health professional utilisation and retention and creates efficiencies at a system level. Many consultation respondents agreed with the benefits identified in the literature; that a highly functional, collaborative interprofessional team provides an array of benefits to the system, health professionals and consumers.

Consultation respondents were broadly divided along professional lines about whether non-medical professionals working to full scope of practice would offer benefits compared with the existing GP-centred primary health care model.

There are potential real and perceived risks to consumers, the health care team and the health care system if changes to health professionals' scope of practice are not appropriately supported or implemented. However, many of these risks are well identified, understood and can be minimised or managed. These risks were reflected in both literature review and consultation evidence, demonstrating a balanced understanding of risks and benefits amongst stakeholders. For example, if collaboration across health professionals is not appropriately enabled through funding policy, technology and leadership, then health professionals may be resistant to working at full scope or operate within siloes, resulting in reduced consumer access or fragmentation of care. Similarly, there are risks if the quality and safety of care is not maintained throughout adoption of changes, which highlights the need for small-scale trial of reforms and strong ongoing research and evaluation mechanisms. Within written submissions, there was divergence along professional lines about whether health professionals working to full scope of practice represented an unacceptable level of risk. Many expressed that this was associated with few major risks, and that maintaining current barriers actually presented a greater risk through suboptimal care, underutilisation of the workforce, increased health care costs and existing siloes. Some disagreed and expressed that current professional boundaries should be maintained.

The barriers, enablers, risks and benefits identified through the above evidence have been broadly grouped into five emerging themes, which form the foundation for further discussion in this Issues Paper:

1. **Legislation and regulation** – where legislation or regulation authorise or inhibit health professionals in performing a particular activity;
2. **Employer practices and settings** – service-level practices and settings which influence health professionals' ability to work to full scope of practice, including credentialling, role design, and employment models;
3. **Education and training** – pre- and post-professional entry learning and qualifications, including professional entry requirements and opportunities for professional development, mentoring, supervision and upskilling, and interprofessional learning;
4. **Funding policy** – the way funding and payment is provided for delivery of health care;
5. **Technology** – integrated and accessible digital tools, communication and information sharing.

Barriers or enablers within any theme may overlap with those in other themes and are cross-referenced accordingly in the following sections. Action in one area may inhibit or support health professionals working to full scope of practice.

Emerging themes from analysis

This section summarises key findings from Phase 1 consultation, and highlights where these findings accord with findings from the literature review undertaken as part of this Review.

1. Legislation and regulation

Context

Legislative and regulatory settings are an essential underpinning for all health professionals' authority and ability to work to full scope of practice. Legislation and regulation therefore become natural policy levers with the potential to promote significant practice change. In the context of enabling health professionals to work closer to their full scope of practice, regulation is essential to build trust and confidence across the primary health care system, health professionals and consumers that services will be delivered safely and effectively. This section sets out key policy issues and potential areas of policy change relating to legislation and regulation, noting that this will be a key area of additional focus in Phase 2 consultations and Issues Paper 2.

The primary health care workforce is regulated through a range of means, with a key mechanism being the National Registration and Accreditation Scheme (NRAS). The NRAS regulates 16 professions and is a broadly trusted regulatory mechanism among stakeholders consulted. Responses received during consultations indicated it was not, in itself, a key barrier to reform. However, as summarised below, NRAS does not regulate all primary health care workforces. Furthermore, regulatory approaches used within self-regulated primary health professions do not fully align with NRAS.

Regulated professions: professions regulated under the National Registration and Accreditation Scheme (NRAS) as per the Health Practitioner Regulation National Law that applies in each State and Territory.

Self-regulated professions: regulated by profession-specific colleges and associations. Examples include speech pathology, social work, genetic counselling, exercise physiology and dietetics. These professions may be subject to laws and regulatory codes such as the National Code of Conduct for Health Care Workers, the requirements to work within the National Disability Insurance Scheme, etc.

Unregulated health workforce: other health workers not regulated under the NRAS, subject to legislation and regulation including laws regulating specific activities (e.g., use of medicines and therapeutic goods), health complaints laws, consumer protection laws, or codes such as National Code of Conduct for Health Care Workers, the requirements to work within the National Disability Insurance Scheme, etc. These include allied health assistants, personal care workers and technicians (including pharmacy, dental and anaesthetic technicians).

Outside of the NRAS a range of legislation and regulations include protected titles or 'named' professions who alone are authorised to carry out the function described in that Act or regulation. Examples in the Australian context include at the Commonwealth level, the Therapeutic Goods Act; and at the State and Territory level, legislation governing drugs and

poisons, mental health, radiation safety, Voluntary Assisted Dying, road accident compensation, and termination of pregnancy. The inclusion of named professions in legislation restricts the authorisation to a group of health professions and may exclude others with the competency and qualification to carry out these activities. An example of international practice, which differs from the profession-specific approach taken in Australia, is illustrated above in the UK non-medical prescribing framework, with a similar model also used in New Zealand. This is discussed below.

Challenges

There are known inconsistencies and barriers within the current legislative and regulatory systems governing the primary health care system which prevent health professionals from working at their full scope of practice. One contributing factor is that while a health profession may be competent and qualified to perform a particular activity, they are impeded if the relevant legislation or regulation does not explicitly authorise that profession to perform that activity. This is often a result of legislation and regulation recognising a named profession as able to undertake the activity, rather than identifying the activity and recognising all professions competent and qualified to undertake that activity.

Other perceived barriers result from processes for gaining endorsement for advanced or specialised practice (e.g., prescribing) among NRAS-regulated professions, particularly among non-medical professions. Consultation feedback indicates health professionals perceive overly arduous and inconsistent (even arbitrary) means of accessing endorsement across professions as a key barrier to operating at full scope of practice. For instance, midwifery endorsement for scheduled medicines requires accumulation of 5000 practice hours, amongst other requirements. Other authorisations, such as vaccination (managed by State and Territory governments), are granted through completion of specific courses which themselves differ across professions.

Consultation feedback identified a need for an appropriate regulatory approach for the unregulated workforces, who are becoming an increasingly important segment of the primary health workforce now and more so into the future. Regulation of the various unregulated workers does not align with the approach taken under NRAS, nor within self-regulated professions. The employer-level authorising environment should also be noted as a key barrier or enabler to legislative and regulatory reform, and can itself be inconsistent with NRAS, as discussed further in Employer practices and settings.

A further challenge arises when national programs or regulation are enacted under State and Territory legislation, leading to a disjointed or disparate impact on scope of practice for health professionals. A key example of this 'patchwork' effect is Drugs and Poisons legislation, considered through evidence to date to be the major legislative barrier to health professionals working to full scope of practice. A practitioner may have endorsement to prescribe through their national board, however, be restricted from doing so through their jurisdiction's Drugs and Poisons legislation. Harmonisation of the various State and Territory Acts is a key policy lever to ensure relevant professions have the same authority for prescribing across different jurisdictions, without which Commonwealth-level changes to the PBS for example will continue to be dependent on state-level decision making, which may impede certain authorisations to prescribe in practice. For example, discrepancies remain in the vaccines pharmacists are authorised to administer between jurisdictions under the

National Immunisation Program Vaccinations in Pharmacy (NIPVIP) despite ongoing intergovernmental engagement and advocacy by peak bodies. Similar such authorisations are granted through completion of specific courses which themselves differ between professions. This example illustrates the potential for delayed consumer access and potentially poorer consumer outcomes. This is contrasted with the national prescribing framework used in the UK, as presented below.

NON-MEDICAL PRESCRIBING FRAMEWORK (UK)

The non-medical prescribing framework which has been adopted in the UK, has evolved from the traditional perception that only medical professionals and dentists can have full prescribing rights. Two seminal reports, Cumberland and Crown, challenged this view and recommended extending prescribing rights to other health professionals. In 2002, non-medical prescribing was introduced, requiring non-medical prescribers to complete a certified training course, be registered with their professional regulator, and to only prescribe within their professional expertise and competence. This training is underpinned by a national competency framework for all prescribers. As a result, nurses, midwives, pharmacists, optometrists, paramedics, diagnostic radiographers, podiatrists, physician associates, physiotherapists, therapeutic radiographers and most recently dietitians now have prescribing authority in the UK. This has created efficiencies in the health care system and facilitated improved access to medicines for consumers.

There is a known interplay between legislation and regulation, funding policy and employer practices which may combine to influence a health professional's ability to work to full scope of practice. A key focus of consultation responses was the potential for expanded referral authority to significantly improve health professionals' ability to work to full scope, and for more consistent authorisation of referrals, with the potential to improve consumer outcomes. However, it is noted that barriers to referral authority frequently sit at the level of funding policy (i.e. MBS benefits for specialist consultations are generally restricted to referrals from a GP, disadvantaging patients who are referred directly by non-medical health professionals), as explored in greater depth in [Funding policy](#) . In other instances, employer-level practices can be more significant barriers than legislation and regulation (i.e., when health professionals are impeded by their employer from making referrals for specialist consultations and diagnostics).

RISK BASED FRAMEWORK (ONTARIO, CANADA)

Health care in Canada has traditionally been regulated through separate statutes and exclusive scopes of practice for each profession. However, Canada has seen a shift towards umbrella frameworks with overlapping scopes of practice, starting with the Regulated Health Professions Act 1991 in Ontario. These frameworks apply uniform standards to health professions, setting out consistent provisions for government, registration, and by-law making powers. They also include specific regulations for individual professions that confer title protection and broad, non-exclusive scope of practice statements. In addition, the umbrella legislative frameworks list several controlled or restricted acts (such as vaccination), aimed at balancing the promotion of interdisciplinary care while still restricting higher risk activities to specific professional groups. The introduction of overlapping scopes of practice through these frameworks has resulted in enhanced flexibility for providers and has encouraged interprofessional practice.

Opportunities for improvement

A range of potential policy solutions have been raised through evidence gathered to date and will be the key focus of Phase 2 consultations which will follow this paper. It is further noted that any legislative or regulatory policy solution would need to be accompanied by actions targeting leadership, culture and employer practices to ensure reform is implemented consistently and at the service level. For self-regulated professions, this would require engagement with the relevant regulatory bodies, in order to ensure true system-wide implementation. Potential policy solutions may include:

- **Harmonising Drugs and Poisons legislation across states and territories**, with a view to better alignment. A key goal of this harmonisation would be to ensure clarity and consistency of prescribing rights across health professions and across jurisdictions. This would be key to ensure that any changes to the PBS, for example, filter into practice consistently across jurisdictions.
- **Acknowledging the overlapping nature of scope of practice through legislation and regulation**, such as through a more risk-based and/or activity-based process of regulation. This would involve shifting scope of practice regulation to focus on specific activities, then mapping to health professionals who are already competent (or could become competent) to perform that activity (task-based regulation process), rather than solely through named professions. An exemplar risk-based framework from Ontario, Canada is presented above, in which vaccination is an example of an activity which falls under non-specific scope of practice. In the Australian context, a similar approach was applied in some jurisdictions during the COVID-19 pandemic, in which vaccination authorisation was granted across professions that met certain competency criteria.

- **Reviewing the approach to named professions or protected titles in Commonwealth, state and territory legislation**, based on the risk-based approach referred to above. The aim of reform would be to create a consistent authorising environment across jurisdictions for all health professionals competent and qualified to perform relevant activities to be enabled to perform that activity. Relevant legislation could include the Therapeutic Goods Act and Veterans' Affairs Legislation (Commonwealth); and legislation governing drugs and poisons, mental health, radiation safety, voluntary assisted dying, road accident compensation, and termination of pregnancy (state and territory level).
- **Introducing greater harmonisation in referral authority** between primary health care professions, for example to diagnostics, specialists, and other health professionals. A combination of regulatory and funding policy changes will likely be required to maximise access to referrals across all professions, including non-medical professions, with this being a priority for further exploration in the next round of consultation.
- **Reviewing self-regulated and unregulated workforces to ensure an appropriate regulatory and authorising environment.** In the presence of above policy solutions around risk-based regulation approaches, there would be a likely need to consider the scope of practice of self-regulated professions and unregulated workforces to ensure consistency and equity in ability to work to full scope. An alternative policy option is for additional unregulated workforces or self-regulated professions to become regulated under the NRAS, noting that different models of regulation were subject to in-depth consideration and negotiation during the establishment of NRAS in 2010.
- **Streamlining processes for endorsement** for advanced or specialised practice roles for non-medical professions, seeking to enact a more consistent approach to assessing health professionals' readiness to achieve endorsements across professions. For instance, the appropriateness of minimum practice hour requirements applying to some professions but not others could be considered. This is particularly pertinent where different health professionals have different qualification requirements for the same competency, noting that post-professional entry learning may vary depending on what is covered in professional entry qualification. There may be further opportunity to standardise methods of endorsements where competencies apply across multiple professions, using evidence-based evaluation and assessment approaches.

Potential benefits

Evidence to date suggests there are potential benefits to legislative and regulatory reform to enable health professionals to work to full scope of practice, including:

- **Better access to care and improved continuity of care** for consumers, as regulatory and legislative barriers are removed for certain health professionals to provide certain services. This is likely to result in consumers being more consistently able to receive the care they need at lower cost, potentially leading to improved consumer outcomes.
- **Improved workforce satisfaction and retention**, as health professionals are enabled to work to their full scope of practice without the presence of arbitrary or inequitable legislative and regulatory barriers.
- **Improved interprofessional trust**, where the system enables and promotes a shared understanding of overlapping scope of practice across professions. This relates primarily

to the potential of service-level culture to promote shared understanding, respect and trust, which support the delivery of multidisciplinary care.

Questions for further consultation:

- What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice?
- To what extent do you think a risk-based approach is useful to regulate scope of practice (i.e., one which names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles)?
- What do you see as the key barriers to consistent and equitable referral authorities between health professions?

2. Employer practices and settings

Context

Employer settings, teams and structures have significant impacts on the extent to which health professionals are able to work to full scope of practice. Employer practices and settings interface with system-wide factors, such as legislation and regulation, funding models and digital infrastructure, to enable or restrict health professionals from working to their full scope of practice. While system-wide factors are critical for overall authorisation to perform particular activities, they must be accompanied by authorising environments within individual practices and other primary health care settings (that is, environments which provide legitimacy and support to enable health professionals to work to full scope of practice).

The Australian primary care landscape is comprised of a large number of services and employers, including predominantly sole or small group practitioners. It is dispersed across public, private and non-government sectors, and lacks a single employer (compared to, for example, public acute services at the State and Territory level). This inherently introduces complexity in implementing reform across the primary health care sector where no single level of government has the legislative and policy authority to mandate such change. This context also creates a barrier to different health professionals working together when they work under different employers.

Challenges

Reform related to scope of practice, needs to be supported by the presence of enabling and authorising environments at the individual service level and across multi-service care teams. Consultation feedback identified that the authorising environment which allows practitioners to operate at full scope in primary care across different employers and settings is unclear, inconsistent, and sometimes appears arbitrary. In particular, a lack of consistency was highlighted in terms of which activities health professionals are supported to perform, at both the health service level and jurisdictional level. That is, the same health professional may be authorised to perform a particular activity (such as vaccination) at one health service and not another depending on the jurisdiction and individual employers. In some cases, this may

relate to concerns about professional indemnity and public liability insurances. This is despite nationally consistent accreditation of training and regulation of practice standards. The midwifery example below illustrates this effect.

MIDWIFERY CONTINUITY OF CARE

Employment practices are especially relevant for continuity of care for models such as midwifery-led care. This model provides mothers with a continuous midwife relationship across health care settings and is strongly associated with optimal consumer outcomes and improved experience. Midwifery-led care is established best practice internationally and a core National Health Service (NHS) policy in the UK. In an Australian context, barriers were raised through consultation relating to midwives' scope of practice being inconsistently recognised by different health services at which they work. Removing employer-level barriers to ensure midwives are able to consistently perform activities they are trained to do, regardless of the setting in which they are providing care, has the potential to increase the provision of midwifery-led continuity of care models and therefore significantly improve patient outcomes.

Opportunities for improvement

A range of potential solutions have been put forward, including targeting leadership and culture to increase employers' understanding and recognition of health professionals' endorsements and specialised skills, as well as strengthening local clinical governance mechanisms to build assurance. The introduction of a more consistent credentialing model, appropriately aligned with health facility role delineation (similar to that used in the acute health system) has also been suggested. These and other enablers would seek to build acceptance that a qualified and regulated health professional should be permitted to work to full scope across effectively identical care settings.

As health policy direction moves towards multidisciplinary care teams in primary health care settings, it is critical that these teams be adequately supported and promoted at the employer level for coordinated and collaborative care to flourish. A fundamental underlying enabler for health professionals to work to full scope of practice is the need for trusted relationships between all health professionals involved in care, regardless of employer and setting. In the absence of interprofessional trust that each member of the multidisciplinary care team members is competent to perform activities they are experienced and trained to do, there will remain a barrier to health professionals working to full scope of practice at the service delivery level.

Likewise, without appropriate enabling employer practices and settings, there is the potential for multidisciplinary care teams to result in the formation of new siloes rather than working in a truly connected way. This is particularly pertinent as the population develops more complex and chronic health needs, for which existing episodic, single-discipline models of care are not appropriate and are unlikely to achieve good outcomes for the consumer.

The community paramedicine case study below presents an exemplar for delivery of multidisciplinary care between small rural health services and paramedic response. Efforts to significantly increase the presence and role of community paramedics in primary care have

recently been undertaken in the UK. However, there are currently several barriers to enable paramedics to work to full scope of practice in the Australian context. Paramedic competencies are overseen by both the National Paramedicine Board and Jurisdictional Ambulance Services, which between them may hold different definitions of work roles to be performed. Moreover, dual-qualified paramedics (such as nurse-paramedics) are only able to be employed as one role or the other under existing Enterprise Bargaining Agreement (EBA) settings. These employer-level challenges would need to be overcome to ensure community paramedics are enabled to work to their full scope.

COMMUNITY PARAMEDICINE

Paramedics are trained to perform a broad scope of practice that could benefit the community by providing consumer care in their home or in community settings, rather than via the acute care system. Consumers with chronic illnesses could particularly benefit from a community paramedic service model. However, it is well established that what paramedics are credentialed to do in their specific clinical setting often excludes certain activities they are trained and able to do, such as wound management, vaccination, testing to support chronic disease management, catheterisation, prescribing or providing medicines. There is particular importance placed on community paramedic roles in regional and remote communities. For example, by adapting their usual work role the Ngangganawili Aboriginal Health Service community paramedicine service (Martu Country, Western Australia) has seen initial positive outcomes including improved primary care availability over the wide geographic area and improved continuity of care from on-site primary care to inpatient settings where required.

The importance of a consistent national approach to scope of practice is illustrated by the example of inconsistent non-medical prescribing across jurisdictions. For instance, Queensland Health have determined that the pharmacist registration process is sufficient for pharmacists to prescribe for Urinary Tract Infections in primary care statewide, and other jurisdictions are currently trialling or implementing similar programs. However, Queensland pharmacists would not currently be able to undertake the same role in other Australian jurisdictions, as they require different training and practice processes. These variations in scope recognition impact not only the health professional but also consumers who cannot access consistent care locally, or in this case nationally.

Potential enablers to create the conditions at an employer level for health professionals to work to full scope of practice are provided below. These are non-exhaustive and will be subject to further exploration throughout future phases of consultation.

- **More consistent approaches to recognition of health professionals' qualifications across settings.** A consistent national approach to the authorising environment for primary health care professionals' scope of practice is important to ensure they are able to use the full extent of their skills regardless of their employer. A culture of interprofessional trust, driven by leadership, is critical to underpin this. Potential policy options include introduction of minimum practice standards or introduction of credentialing to primary health care settings, with a goal of consistency with the NRAS. Training requirements are explored further in [Education and training](#).

- **Enabling environments for primary health care professionals to work together across different employers** to deliver care to individual patients. Health professionals need to be supported by appropriate policies and procedures to form and deliver care as multidisciplinary teams, which should aim to break down siloes between disciplines and prevent the formation of new siloes. Employer-level leadership should actively promote a culture of interprofessional trust to support this. It is noted that health services are currently not consistently funded directly to provide care coordination or other collaborative functions. This is discussed in [Funding policy](#).
- **Establishing models of multidisciplinary care for target patient cohorts** which identify the patient need, the activities required to meet this need and roles and scope for different members of the care team. Cohort-based teams are established for particular conditions, such as diabetes and cancer care, in Australia and elsewhere. It is critical that trust and responsibility for care are appropriately shared across the team and that all members understand and respect each other's qualifications and competencies.
- **Strengthening clinical governance mechanisms in primary health care settings**, which could build trust, confidence and assurance in care delivery systems and transdisciplinary processes, as it has done in the acute care sector for decades. Primary Health Networks (PHNs) for example could be well placed to provide local and regional support and consistency for primary care clinical governance mechanisms.
- **Progressing digital enablement at the employer level**, a complement to broader system-wide digital enablement discussed in [Technology](#). It is the responsibility of the employer to ensure the service is appropriately interconnected with broader digital infrastructure, and that health professionals are equipped to use it and have equitable access.

Potential benefits

Evidence to date suggests the following key potential benefits of policy changes in this area:

- **Improved consumer access** to consistent primary health care services across settings and health professionals, and increased continuity of care resulting in greater capacity for positive consumer outcomes.
- **Improved workforce satisfaction and retention** as health professionals' competencies are consistently recognised regardless of health care setting.
- **Improved capacity to work effectively as multidisciplinary teams** if supported by appropriate workplace practices, enabling confidence and trust to be built across the multidisciplinary team.
- **Improved accountability, quality and safety** related to strengthened clinical governance mechanisms and rigour, including support from PHNs.

Questions for further consultation

- What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)
- Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?
- How can multidisciplinary care teams be better supported at the employer level, in terms of specific workplace policies, procedures, or practices?

3. Education and training

Context

Education and training are essential elements in supporting the ability of primary health care professionals to work to full scope of practice. As summarised elsewhere in this document, health professionals complete training that is accredited to national standards in order to enter their profession, defined by NRAS (for NRAS-regulated professions) and national colleges and professional associations (for other self-regulated professions). NRAS defines clear requirements for registration of professions including medical specialities, and an accredited qualification is one of these requirements.

Accreditation: Refers to a formal process of approval for a program of study or training that provides a person who completes that program or training with the knowledge, skills and professional attributes needed to practice their health profession or undertake that activity.

Registration: Formal approval for a person to practice as a health professional in Australia.

Endorsement: Recognition by National Boards that a person has additional qualifications and expertise in an approved area of practice.

Continuous professional development standards are defined by National Boards (for NRAS-regulated professions). However, requirements for post-registration/profession entry authorisations and endorsements (such as diabetes educator or scheduled medicines endorsement for podiatrists) are less clearly defined. Under NRAS, obtaining a speciality or endorsement requires a formal qualification.

Access to ongoing training and education is important to ensure health professionals are able to work to the full scope of practice, as well as to develop new skills. Responsibility is placed on the individual health professional to access continuous professional development and ongoing training. There are increasing opportunities to deliver technology-assisted education and training, including virtual supervision, to increase access.

Challenges

Although endorsements of NRAS professions appear on a public register, there are known gaps in consistent practical recognition of their endorsements at the employer level, as discussed in [Employer practices and settings](#). This is even more problematic for additional authorisations and endorsements for self-regulated professions and unregulated workforces.

As previously discussed, recognition of health professionals' scope of practice rests on interprofessional trust, which is not always within the individual health professional's direct control and relies on leadership and team culture. Notwithstanding that endorsements for NRAS-regulated professions appear on a public register, there are known 'custom and practice' issues with practical recognition of these endorsements across NRAS professions. This means that a health professional may have skills that are unrecognised by employers and colleagues and may go unused, meaning they are not able to work to their full scope of practice. Conversely, overly prescriptive regulatory requirements for accreditation of micro-credentials and additional skills training can reduce overall workforce flexibility.

The Australian primary health care system features a proliferation of education and training requirements for particular competencies, which differ across health professions. Some international jurisdictions have dealt with this complexity through consolidation of health professions into a smaller number of national boards, as taken by the NHS in the UK who regulate 15 healthcare professionals under a combined Health and Care Professionals Council. Training requirements also apply inconsistently across professions in some cases; for example, different vaccination training applies to nursing and pharmacy professions (noting different requirements could be influenced by different professional capabilities, setting and role). In consultation feedback, health professionals raised several examples of endorsements they perceived as overly arduous to obtain, such as endorsed status in midwifery.

There is potential to introduce more common interprofessional competencies and skill sets, particularly those related to multidisciplinary care. For instance, Australia has national standards under which health professionals are endorsed for prescribing, and there is significant work, led by Ahpra and the National Boards towards common interprofessional competencies in the area of cultural safety. In other countries, such as Canada, there are more defined national competencies in the area of interprofessional practice, as illustrated in the risk-based framework used in Ontario (see [Legislation and regulation](#)). While it is important to maintain the core skills within professions, interprofessional education plays a key role in allowing different health professionals to increase their exposure to primary care and to other professionals, allowing care teams to build understanding and recognition of each other's capability and scope of practice.

NHS HEALTH EDUCATION ENGLAND – UNITED KINGDOM

The NHS has developed a consolidated national education for primary care, including a toolkit which provides practical guidance on effective implementation of multidisciplinary teams (part of a suite of resources and supports offered by Health Education England to support workforce design). The toolkit is a step-by-step guide to help progress a 'one-workforce' approach across health and care organisations, drawn from a range of health and social care disciplines, designed to work together in a multi-functional team across clinical pathways for the benefits of patients/service users. It focuses on six enablers to effective multidisciplinary teams: skill mix and learning, planning and design, working across boundaries, shared goals and objectives, communication and culture.

Opportunities for improvement

A range of potential solutions may apply to progress reform in the area of education and training. These would broadly seek to implement better access to education and training, more consistent expectations and recognition of learning, and better promotion of multidisciplinary and interprofessional forms of training.

These include:

- **Establishing greater clarity at the system level** about expectations and requirements of post-profession entry learning. This may include harmonisation of education and training requirements for the same competency between different professions, to ensure requirements are reasonable and equitable, noting previous education undertaken. As stated in Employer practices and settings, this needs to be accompanied by more consistent employer level-recognition of learning and skills post-profession entry.
- **Establishing a nationally consistent approach in promoting and implementing common interprofessional competencies**, to equip health professionals with specific skills common across multiple professions. These common competencies could follow the example of the national standards for prescribing which equip health professionals who meet these competencies (e.g., nurse practitioners, and pharmacists in some jurisdictions) to prescribe medicines without undergoing additional training.
- **Promoting multi-professional learning**, as exemplified by the UK example above. In Australia, an exemplar of this approach is found in the Queensland Allied Health Leadership and Advancing Practice Framework, which promotes a blended approach to recognition of Advancing Practice across allied health professions, and practice which contributes to the development of the wider health care team and broader. Existing progress in this area is noted, such as an Ahpra Board Accreditation Committee statement to embed interprofessional education as a priority area of work.
- **Ensuring ongoing education and training are accessible**, including through protected time for education and training, more technology-assisted support, supervision and mentoring. Consultation participants also voiced a desire for more incentives to undertake education and training including on entry into professions (e.g., through scholarships).

Potential benefits

Benefits of strengthened education and training are likely wide-ranging and may include:

- **Improved consumer outcomes** as care is delivered by a more highly skilled workforce and more multidisciplinary care delivered by teams trained to work together effectively;
- **Improved workforce satisfaction and retention** due to increased access to ongoing education and training to increase their skills and competencies;
- **Improved interprofessional trust** as health professionals are enabled to gain experience working collaboratively as multidisciplinary care teams, increasing their exposure and understanding of other primary health care professionals' competencies and scope of practice.

Questions for further consultation

- What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?
- How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?

4. Funding policy

Context

Primary health care in Australia is funded and paid primarily through the Medicare Benefits Schedule (MBS). The MBS operates through a fee-for-service mechanism, meaning that primary health care providers are paid per episode of care delivered by a specified type of health professional.

The Medical Services Advisory Committee (MSAC) is an independent non-statutory committee which makes recommendations to Government about new or amended services proposed for funding under the MBS. Proposals for new or amended services are assessed on the basis of comparative safety, clinical effectiveness, cost effectiveness and total cost based on best available evidence. MSAC also advises on the circumstances and rules associated with listing items on the MBS.

There are also a number of alternative funding and payment models to fee-for-service, including block, bundled, delegated, blended & capitation, program grants, and salaried workforce. These mechanisms are already used in Australian primary health care settings, including Aboriginal Community Controlled Health Organisations (ACCHOs) and smaller State and Territory Government operated rural health services. Additionally, blended funding (referring to a blend of flexible lump-sum payments attached to the patient, in addition to fee-for-service funding for each visit made) is anticipated to be introduced into the broader primary health care system as part of upcoming [MyMedicare reforms](#).

PRIMARY HEALTH CARE FUNDING TYPES

Fee-for-service: payment for each episode of care.

Block funding: lump sum payment allocated to service provider.

Bundled funding: single payment for all services related to a specific treatment, condition or patient parameter, possibly spanning multiple providers in multiple settings.

Blended funding: combination of funding streams, such as block/bundled plus fee-for-service.

Capitation: payment based on the number of patients enrolled or registered with the practice.

Value-based care: Payments which link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics.

Program grants: lump sum payment allocated to a specific program.

Salaried workforce: health professionals earn a salary rather than being funded through one of the above funding models.

Delegated funding: a term which appeared through consultations, which refers to practices where a named health professional delegates activities related to care to another health professional but receives payment for that service.

There are examples internationally where alternative funding models are used to specifically drive multidisciplinary collaboration and care teams. A Canadian example is presented below, which illustrates how the choice of funding model can create incentives to strengthen primary care.

FAMILY HEALTH TEAM (FHT) – ONTARIO, CANADA

The FHT model was introduced in 2005 as a part of the Ontario government's strategy to improve access to team-based primary care. Most FHTs consist of family physicians, nurses, and other health care providers (such as allied health and pharmacists) who share responsibility and work collaboratively to provide comprehensive primary care. The FHT collaborative practice model has required significant changes in the delivery of primary health care services. Medical professionals in FHTs are compensated via blended capitation and salary, to encourage the delivery of comprehensive primary health care to patients. This funding model has facilitated team-based care that allows each health professional in the team to work at their full scope of practice, enabling efficient collaborations that meet patient needs, when and where they need it.

Challenges

Evidence to date highlights that funding and payment policy settings underpinning the primary health care system are a significant issue with wide-ranging impacts on the ability of health professionals to work to full scope of practice, and for consumers to get timely access to optimal multidisciplinary care. Reform to primary health care funding and payment could

yield benefits in terms of improved quality, safety, connectivity, collaboration and consumer outcomes.

While consultations raised some concern about the amount of funding available through the MBS, there were greater concerns that overall model for funding and payment of primary health care (not just the MBS) is not flexible or broad enough to effectively support long-term care relationships, continuity of care or multidisciplinary care. In other words, if payment rules do not explicitly support co-ordinated multidisciplinary care delivered by health professionals working to their full scope of practice, there is the potential for consumer outcomes to be negatively impacted.

Opportunities for improvement

There are opportunities to make policy changes to primary health care funding and payment models, which could enable both individual health professionals and multidisciplinary care teams to work more effectively to full scope of practice. It should be noted that a number of reviews including the *Strengthening Medicare Taskforce Report (2022)* have not only identified funding policy as a key barrier to reforming the Australian primary health care system, but also led to major policy changes to funding to rectify them, i.e., MyMedicare.

The key funding-related solutions relevant to the Australian context, and discussed at length in the evidence, serve to increase the flexibility in how primary care is funded and delivered, and by whom. They also promote more multidisciplinary delivery of primary care. Potential policy solutions which may achieve these aims include:

- **Block, bundled and blended funding** which enable care to be delivered more flexibly, across different care settings and health professionals. As stated above, MyMedicare reforms are expected to introduce more blended funding into GP clinics.
- **Funding policy and payment which incentivises multidisciplinary care teams**, such as in the Canadian example above, and with other international examples including patient-centred medical homes in the US and primary care homes in the UK. Evidence to date also suggests capitated and blended funding are able to better support primary care for people with complex health needs, who are most in need of multidisciplinary care teams and for whom current GP Management Plan arrangements are often inadequate.
- **Enabling non-medical professionals to make referrals by reviewing MBS payment rules.** Opening up access beyond the medical profession to referrals for certain MBS subsidised specialist services addresses a widely discussed gap in the primary health care system and overreliance on GPs to manage all referrals. A range of examples were raised through the evidence of opportunities for non-medical professionals to make direct referrals to specialists and other health professionals, as well as for GPs to make particular types of referrals (such as to MRIs) and prescribe a wider range of medications. This would need to be accompanied by corresponding changes to MBS payment rules, where required, as well as more systematic use of digital health support through My Health Record for all team based professional interactions.
- **Funding episodes of care regardless of profession.** In consultations, many health professionals raised that they wished to see more parity in how professional services are funded, i.e., a single MBS rate for a particular activity irrespective of who delivers it. This approach is based on the existing fee-for-service model and may need to be

accompanied by additional reforms in order to achieve improvements in continuity of care or collaborative care.

Reform to funding policy is not without risks, and any change may carry the risk of incentivising or disincentivising certain types of care delivery. For instance, delegated funding models reinforce the status quo GP-centred model of care to a greater extent than alternatives such as blended or block funding, potentially limiting the flexibility of non-medical professions to work to full scope of practice. Other risks, such as poor team cohesion, scope overlap and perceived role threat, could potentially result from a move away from the current GP-centred model and towards more multidisciplinary and collaborative care. Policy reforms to funding should also be considered carefully as a supporting and enabling component of reforms in legislation and regulation, education and training, and employer practices and setting, rather than in isolation.

Potential benefits

Initial evidence suggests that reform to primary health care funding policy could yield benefits including:

- **Greater continuity of care** by making it easier for people to receive primary health care across or within health care settings, where and when they need it.
- **Reduced time and cost burden along the care pathway** by enabling consumers to access referrals to specialist and some diagnostic services through the relevant health professional, not only via their GP.
- **Reduced burden on GP workforce** as other health professionals are enabled to work closer to full scope of practice and in a more collaborative way.
- **More effective chronic illness management** by addressing disincentives to long-term and team-based care relationships, which are to an extent inherent to fee-for-service models.
- **More collaboration between health professionals** by streamlining care pathways, with the potential to improve interprofessional trust, confidence and respect, workforce satisfaction and stability.

Questions for further consultation

- How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?
- Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary health care system?
- What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?

5. Technology

Technology is recognised as a significant factor enabling primary health care providers and care teams to work in a connected way. Robust digital health infrastructure may enable consumers and health professionals to access and share information, and to work together more collaboratively and equitably, by ensuring all health professionals have visibility over the same information. In this way, technology is a key enabler for both individual health professionals and multidisciplinary care teams to work to full scope of practice and achieve better consumer outcomes.

The Strengthening Medicare Taskforce, in their final report, emphasised the importance of modernising data and digital technology to support safe and quality consumer-centred care. Australia's *Digital Health Blueprint 2023-33* echoes this vision, seeking to implement system-wide digital reform to enable health care to be delivered more effectively, including in the primary health care system.

Challenges

Evidence from consultation highlighted key issues with the existing primary health care IT infrastructure, which frequently impacts practitioners' ability to work to their full scope of practice. Consultation participants voiced frustration with barriers to information sharing between health services, due to siloed systems which are not interoperable (i.e., are unable to communicate with each other). Underuse of My Health Record, inconsistent information sharing processes and lack of secure messaging solutions were all specifically recognised as contributing to this problem.

Opportunities for improvement

The Digital Health Blueprint outlines an Action Plan involving Commonwealth, States, Territories, industry, consumers and professions to address these concerns and work is currently underway to strengthen the use of My Health Record to support these reforms. In addition, a range of digital health solutions, such as embedding telehealth models, have been implemented at jurisdiction-specific levels across Australia, helping to remove barriers to health professionals working to their full scope of practice and improving access to care. This Review seeks to build on these existing policies and reforms to embed and support adoption of robust digital health solutions in primary health care settings. In particular, it will

focus on how digital solutions can enable health professionals to operate at full scope and enhance collaboration amongst multidisciplinary care teams, which will become an increasing focus within the primary health care system.

Evidence to date suggests that a key technology enabler which would strengthen primary health care is real-time integrated patient information, including event notifications. Although My Health Record has been implemented in the Australian health system since 2012, there are significant opportunities to improve visibility of the patient environment, such as providing real-time information about patient referrals, diagnostics, prescribing, treatment plans and discharge summaries. Being able to view and use this information in real-time will enable health professionals to implement team-based care, make better-informed and safer care decisions, whilst allowing the consumer the choice to become more involved and empowered in their own care. An exemplar from the Canadian context is presented below and provides an example of how dual patient-facing and information sharing systems can strengthen the delivery of primary health care.

MYHEALTH RECORD AND MYAHS CONNECT – ALBERTA, CANADA

Alberta Health Services (AHS) is Canada's first and largest province-wide, integrated health system, responsible for delivering health services at more than 900 facilities, including primary health care facilities. The MyHealth Record enables consumers to access, add to and track their personal health information, such as diagnostics and prescribing, which are visible to their health providers. The platform also enables health care providers to securely exchange messages with one another. MyAHS Connect is a complementary tool that enables patients to interact directly with the AHS, to manage appointments, securely message their health care team, and request prescriptions among other user functionalities. The dual systems have connected health professionals and consumers to AHS to a greater extent, allowing for interoperability between health services, greater consumer participation, and ultimately contributing to better primary health care services.

Potential policy solutions which have emerged through evidence to date are largely consistent with the current broader policy direction and specific strategies relating to digital health technology. These include:

- **Enabling access to real-time patient information**, a key dependency for broader actions to strengthen primary health care and highlighted by the Strengthening Medicare Taskforce as a key action to modernising primary health care digital systems. The Canadian example presented above presents a model where health providers and consumer have visibility over consumer information in real-time, and where complementing information sharing functions are embedded into the tool to enable multidisciplinary care across the AHS. Numerous health professionals shared views that My Health Record may offer a platform to do so but is currently not being used to its full effect. For instance, in the evaluation of the Health Care Homes trial (a multidisciplinary care team-based program and part of the Australian Government's Healthier Medicare initiative), there were opportunities identified for increased My Health Record functionality which was used as the basis of information sharing between providers.

- **Introducing platforms for secure messaging and digital referrals.** Comprehensive implementation of these solutions was described by consultation participants as critical to streamlining care pathways and protecting the security of consumer information. Secure messaging models are established international best practice, including the MedCom messaging system which has been implemented across Denmark for over a decade, and the Canadian example above. In Victoria, the eReferral program enables referrals between providers through an encrypted digital format, managed at the PHN catchment level.
- **Using decision support software,** to assist with the safe delivery of primary health care. This solution was also referenced in the *Digital Health Blueprint*, although is dependent on the availability of reliable clinical data and streamlined information sharing pathways.
- **Mandating participation in a multidisciplinary care team for primary care providers,** a potential reform which would further extend the criticality of robust digital health infrastructure. This model exists in some jurisdictions, such as in cancer care teams in the United Kingdom. However, because it is reliant on a mature digital ecosystem, implementing such a model in the Australian context may carry risks if multidisciplinary care teams are required to rely initially on non-functional or non-digital systems.

Data security continues to be a key risk associated with digital technology, and any collection of sensitive personal data carries the risk of data breaches. It is critical these continue to be managed to the full extent possible in order to enable any of the above solutions involving the storing or sharing of consumer data. Risks of inconsistent or unclear advice from official channels, such as AskMBS, were also raised within consultations. Furthermore, there were calls to ensure that access to digital systems was equitable between all relevant members of the care team (for example, nurse practitioners with prescribing authority to have the same access to prescribing software as GPs). Consumers should continue to be consulted about possible changes.

Potential benefits

Evidence to date suggests that the benefits of modernising digital health technology in the primary health care system may include:

- **Enhanced care coordination** between and within services, as health providers are able to share consumer information efficiently and effectively and have visibility over the same information.
- **Improved continuity of care** and experience of care for consumers, in terms of streamlined referral pathways, lack of reliance on their repeatedly sharing their story to different health professionals, and the ability to engage more actively with their health care and health data.
- **Improved quality and safety of health care,** as decision-making occurs with the knowledge of the consumer's context and health needs, regardless of which health provider is delivering care.
- **Reduced time and cost burden** to consumers, health services and the broader health system, due to reduced reliance on inefficient referral and information sharing systems.

Questions for further consultation

- How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?
- If existing digital health infrastructure was to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?
- What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?

Next steps

Ongoing stakeholder feedback and continued collection of evidence on the barriers, enablers, risks and benefits of health professionals working to full scope of practice in the Australian context is vital to this Review. In particular, review of the legislation and regulatory environment will form a critical piece of upcoming analysis.

A call for public submissions will occur from 23 January to 8 March 2024, for stakeholders to provide written responses to the themes and consultation questions raised in this Issues Paper. A series of stakeholder workshops and discussions will also be held across Australia in February 2024 to provide opportunity for deeper engagement and exploration on the key issues raised.

The feedback from this second phase of consultation will be synthesised with a review of relevant legislation and regulation to produce Issues Paper 2, which will be released in April 2024. Issues Paper 2 will explore the specific policy and system reforms available to address identified barriers associated with health professionals working to full scope of practice. Consultation will occur on the issues and questions raised in Issues Paper 2, before the draft Final Report and Implementation Plan is produced in July 2024. The Final Report and Implementation Plan will be submitted to the Minister for Health and Aged Care in October 2024.

If you would like to provide further feedback, or if you have any questions or difficulties accessing the survey on- line please contact scopeofpracticereview@health.gov.au

