

# Unleashing the Potential of our Health Workforce

## Scope of Practice Review

### Issues Paper 2

16 April 2024

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# 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 practise 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 (referred also in this document as multidisciplinary or team-based care)	Collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. <sup>1</sup> For example, care provided by multidisciplinary care teams.
Continuity of care	Ability to provide uninterrupted, coordinated care or service across programs, health professionals, organisations and levels over time.
Credentialling	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	<p>Professional activities that a practitioner is educated (skill / knowledge), competent and authorised to perform, and for which they are accountable.</p> <p>Individual scope is time-sensitive and dynamic. Scope of practice for individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority / governance) of the service provider.</p>

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<sup>1</sup> World Health Organization. Framework for action on interprofessional education and collaborative practice. 2010. Accessed from: <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>.

General practice	The provision of patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities. <sup>2</sup>
GP-centred primary health care model	Refers to the central role that general practitioners play in primary care.
Health Professionals	For the purposes of this document, this term includes regulated and self-regulated health professionals and the para-professional workforce e.g., health assistants, technicians, care workers, peer support workers.
Health Ministers Meeting (HMM)	The Health Ministers Meeting (HMM) works to progress health issues of national importance which require cross-border collaboration. It is made up of the health ministers of each state and territory government, along with the Australian Government Minister for Health and Aged Care. <sup>3</sup>
Interprofessional Education / Interprofessional Learning	Refers to educational experiences where students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. <sup>4</sup>
Multi-professional Learning	Health professionals from different disciplines learning together, either face-to-face or virtually.
Multidisciplinary Care Team	Multi-disciplinary team care in health care is assumed to mean collaborative care, which 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.
Para-professional workforce	Includes health assistants, technicians, care workers, peer support workers.

<sup>2</sup> Royal Australasian College of General Practitioners (RACGP) Accreditation standards for general practices. Glossary. Accessed from: <https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed/glossary>

<sup>3</sup> Australian Government Department of Health and Aged Care. Health Ministers' Meeting (HMM). Accessed from: [https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm#:~:text=The%20Health%20Ministers%20Meeting%20\(HMM,for%20Health%20and%20Aged%20Care.](https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm#:~:text=The%20Health%20Ministers%20Meeting%20(HMM,for%20Health%20and%20Aged%20Care.)

<sup>4</sup> Adapted from: World Health Organization. Framework for action on interprofessional education and collaborative practice. 2010. Accessed from: <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>.

Practice standards, professional standards	Define the practice and behaviour of a health professional. May include codes of conduct, standards of practice, codes of ethics. <sup>5</sup>
Primary health care	Primary health care is the entry level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions. <sup>6</sup>
Professional capabilities	Identify the knowledge, skills and professional attributes needed to safely and competently practise as a health professional in Australia. Describe the threshold level of professional capability required for both initial and continuing registration. <sup>7</sup>
Professional Guidelines	Provide guidance to health professionals and clarify the Board's views and expectations on a range of issues.
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.
Scope of practice	<p>Professional activities that a practitioner is educated (skill / knowledge), competent and authorised to perform, and for which they are accountable.</p> <p>Individual scope is time-sensitive and dynamic. Scope of practice for individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority / governance) of the service provider.<sup>8</sup></p>
Self-regulated professions	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.

<sup>5</sup> Adapted from: Nursing and Midwifery Board. Practice Standards. Accessed from: <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx#>

<sup>6</sup> Australian Government. Australian Institute of Health and Welfare. Primary Health Care in Australia. Accessed from: <https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/summary>

<sup>7</sup> Adapted from: Ahpra and National Boards. Paramedic professional capabilities released. 2020. Accessed from: <https://www.ahpra.gov.au/News/2020-09-14-Paramedic-professional-capabilities-released.aspx>

<sup>8</sup> Adapted from: Queensland Nursing Council Scope of Practice Framework for nurses and midwives. 2005. Accessed from: [https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0034/372868/nursingscprac.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0034/372868/nursingscprac.pdf)

Supervised Practical Training (SPT)	Experiential learning conducted in a health setting under the supervision of a trained health professional. May include internships and placement experiences, sometimes also be referred to as Work-Integrated Learning.
Team based care	The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers to accomplish shared goals within and across settings to achieve coordinated, high-quality care. <sup>9</sup>
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).

## Acronyms

ACCHO	Aboriginal Community Controlled Health Organisations
Ahpra	Australian Health Practitioner Regulation Agency
EBA	Enterprise Bargaining Agreement
FHT	Family Health Team
GP	General Practitioner
IPE	Interprofessional Education
IPL	Interprofessional Learning
IRL	Independent Review Lead
LHN	Local Health Network
MBS	Medicare Benefits Schedule

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<sup>9</sup> Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. [www.iom.edu/tbc](http://www.iom.edu/tbc).

MPL	Multi-professional Learning
MSAC	Medical Services Advisory Committee
NASRHP	National Alliance of Self Regulating Health Professions
NIPVIP	National Immunisation Program Vaccinations in Pharmacy
NRAS	National Registration and Accreditation Scheme
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
TEQSA	Tertiary Education Quality and Standards Agency
UK	United Kingdom
USA	United States of America



# Executive Summary

The Australian primary care system is supported by a skilled and dedicated workforce. This workforce provides care to Australians in the community, often as the first and most regular point of contact with the health system. A broad range of health professionals contribute to primary care in a range of health care settings. Primary care services include general practice, community health clinics, Aboriginal Community Controlled Health Services, community pharmacy and nursing services, oral health and dental services, mental health services, drug and alcohol treatment services, sexual and reproductive health services, maternal and child health services and allied health services such as those offered by physiotherapists, psychologists, occupational therapists and chiropractors. Many primary care health professionals are self-employed and may be physically located some distance from other health professionals providing care to the same person, which impacts the way healthcare is provided in this setting. This review provides an opportunity to better support this workforce to use their skills more effectively and to work together to meet the needs of the community.

A health professional's scope of practice means the professional activities for which they are educated (including their skills and knowledge), competent, authorised and accountable. The future of primary care in Australia could be improved by supporting health professionals to work to their full scope of practice. There are numerous benefits to this outcome, including a more effective use of health professional skills which will benefit both the primary care team and the individual professional, a better experience of healthcare for the consumer due to improved healthcare access and a more efficient care process.

As part of this review, evidence has been collected through stakeholder consultation and a review of relevant literature, legislation and regulation. The evidence gathered has helped to identify key policy issues and develop a series of potential solutions. There have been numerous opportunities for stakeholders to participate throughout, via in-person consultation forums, and Phase 1 and 2 online surveys.

Evidence collected to date through this Review has described a range of challenges facing primary care health professionals. These include:

- **Poor recognition of the skills that primary care health professionals have**, which impacts how the primary care team is used and how they work together.
- **Inadequate preparation for primary care.** Health professional students may not experience primary care during their training which leads to them being under-prepared to work in primary care. Similarly, once qualified, primary care health professionals may find it hard to maintain their skills, especially if self-employed. It is important for the primary care team to learn together, however this is also challenging for those who are self-employed or located a distance from other health professionals.
- **Legislation impedes health professionals working to their full scope.** Where the law dictates which profession/s are authorised to provide a service, other health professions who may have the same skill are unable to do so. At times, legislation does not keep up with accepted changes in health professional practice. There are

also differences between state and territory legislation that affects health professional scope.

- **Funding and payment arrangements impede health professionals working to their full scope.** Existing funding models restrict some professions from working to their full scope of practice and fail to adequately support primary care health professionals to work together in teams. In addition, funding currently prevents some health professionals from referring patients for services resulting in them having to return to their general practitioner to obtain the referral.

To address these challenges, a series of options for reform have been proposed with the aim of improving primary care by enabling health professionals to work to their full scope of practice. The proposed reforms fall under three themes:

- Workforce design, development and planning
- Legislation and Regulation
- Funding and payment policy

Implementation of the proposed reforms would be enabled by culture, leadership and clinical governance mechanisms that support the changes.

The first theme, *Workforce design, development and planning*, includes three proposed reform options which together aim to contribute to primary care by supporting health professional to achieve and maintain the skills they need for their role. Reform options proposed in this theme would further strengthen the system by enabling workforce planning that meets community needs.

Reform Option **1: *National skills and capability framework and matrix*** describes the development of a matrix that sets out the skills and capabilities of health professionals, including members of regulated, self-regulated and unregulated professions. A skills and capability framework would contribute to better recognition of health professional skills and strengthen the system by informing workforce planning. This reform is foundational for all remaining reform options and integral to facilitating health professionals to work to their full scope of practice.

Reform Options **2: *Develop primary health care capability*** and **3: *Early career and ongoing professional development includes multi-professional learning and practice*** describe support for the development and maintenance of a skilled primary care workforce that practises collaboratively with a central focus on meeting consumer and community needs.

The second theme, *Legislation and Regulation*, includes three reform options which aim to make system-wide changes to strengthen elements of the healthcare system by enabling health professionals to use all of their individual and combined skills to flexibly meet community need.

Reform Option **4: *Risk-based approach to regulating scope of practice to complement protection of title approach*** aims to remove legislative barriers that restrict health professionals from practising to their full scope. This reform combines with Reform Option **5: *Independent, evidence-based assessment of innovation and change in health workforce models*** which is designed to inform legislation and regulation and enable these mechanisms to keep pace with practice change and best practice evidence.

Reform Option **6: *Harmonised drugs and poisons regulation to support a dynamic health system*** aims to improve legislative and regulatory consistency between states and territories with a view to improving national consistency and clarity in health professional scope of practice.

Under the final theme, *Funding and payment policy*, two reform options have been proposed which would serve to support the primary care team. Reform Option **7: *Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice*** aims to provide flexible funding models that support the primary care team to work together more effectively. Reform Option **8: *Direct referral pathways supported by technology*** aims to improve the way health professionals refer patients for investigations and/or to another health professional. This reform is anticipated to improve collaboration and communication between health professionals and the efficiency of care provided to consumers.

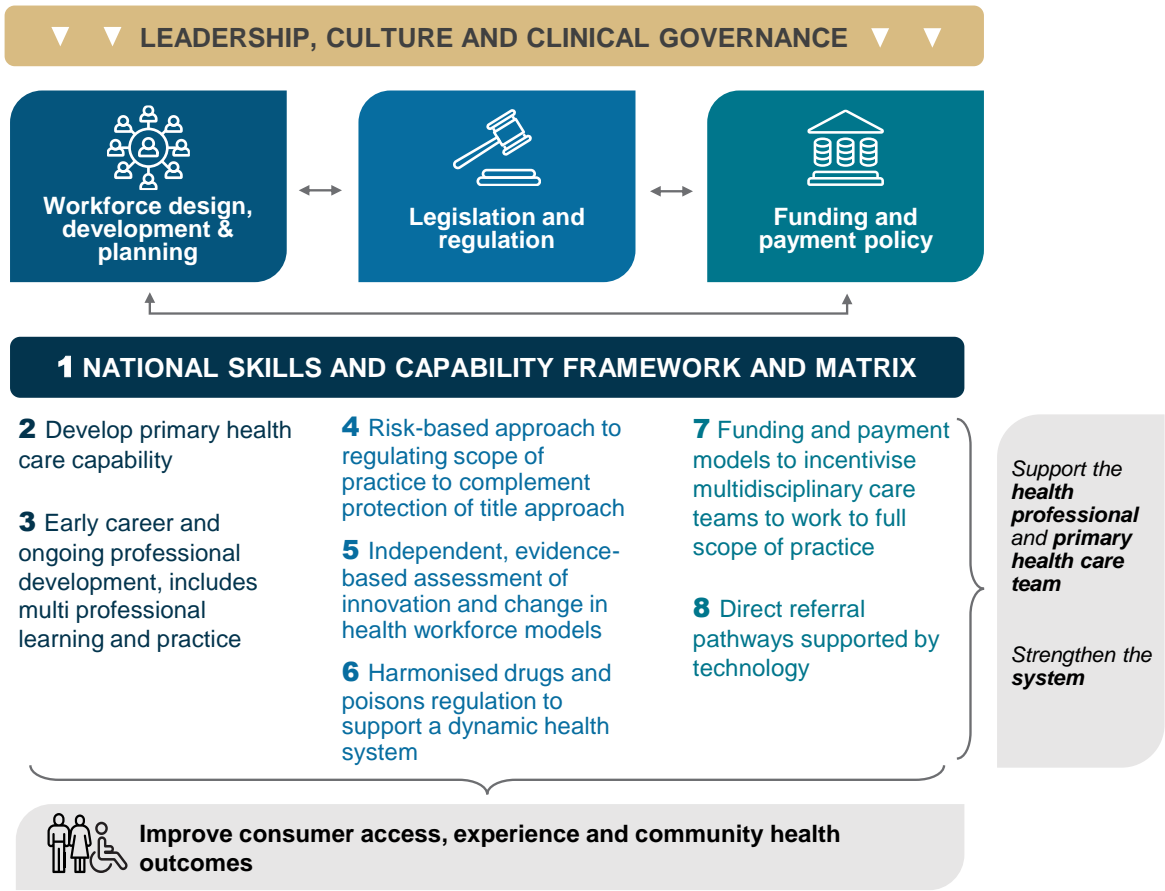
The reform options proposed by the Review would collectively improve the function of primary care health professionals and teams by enabling each to work to their full scope of practice. Fundamental to this outcome is a clear view of health professional skills required, a comprehensive understanding of community needs, and the ability to effectively connect these factors through:

- Workforce design, development and planning
- Legislation and regulation
- Funding and payment policy.

The National Skills and Capability Framework and matrix will be instrumental in achieving this aim.

The Review will seek public feedback through a further round of consultations to consider in detail the reform options provided in this paper and assess their potential to meet the needs of communities across Australia. The Review team will consider this feedback before refining and finalising the reform options into a Final Report and recommendations.

Figure 1: Overview of Reform Options in this Issues Paper



# 1. Background

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 February 2023, the Strengthening Medicare Taskforce Report outlined priority recommendations to improve primary care, including a review of barriers and incentives for all health professionals 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. Titled *The Unleashing the Potential of our Health Workforce, Scope of Practice Review* ('the Review'), the Review is being conducted in four phases between September 2023 and October 2024.

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, barriers and enablers associated with health professionals working to their full scope of practice. Full scope of practice means the professional activities that a health professional is educated (skill/knowledge), competent and authorised to perform, and for which they are accountable.

In Australia, the primary health care workforce is regulated through a range of means, with a key mechanism being the National Registration and Accreditation Scheme (NRAS) which regulates 16 health professions. A core component of the Review is understanding the regulatory landscape in which all primary health care professionals (including regulated, self-regulated and unregulated) practice and operate within. The regulatory landscape in this Review considers all legislation and regulation which may directly or indirectly regulate the scope of practice of health professionals working in the primary health care setting.

In addition, the Review is considering the conditions which enable multidisciplinary care teams to work at their full scope of practice to deliver better care. 'Multidisciplinary care team' in health care is assumed to mean 'collaborative care', which 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.<sup>10</sup>

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<sup>10</sup> World Health Organization. Framework for Action on Interprofessional Education and Collaborative Practice. 2010. Accessed from: [https://iris.who.int/bitstream/handle/10665/70185/WHO\\_HRH\\_HPN\\_10.3\\_eng.pdf?sequence=1](https://iris.who.int/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1)

The Review is part of a broader suite of strategies and policy reform aimed at strengthening Australia's primary health care sector. The Australian Government 2023-24 Budget provided a \$6.1 billion investment into Medicare to lay the foundations for significant reforms. Specific measures as part of this Budget included:

- \$445.1 million over 5 years to enable general practices to engage nurses, midwives and allied health professionals to help improve the quality and accessibility of multidisciplinary primary care;
- \$143.9 million over 2 years to encourage GPs to stay open for longer hours;
- \$98.9 million over 4 years to connect frequent hospital users to general practices to receive comprehensive, multidisciplinary care in the community;
- \$79.4 million over 4 years to support Primary Health Networks to commission allied health services to improve access to multidisciplinary care for people with chronic conditions in underserved communities.

Alongside significant Budget measures, there are numerous other federal, state and territory policies, strategies and reviews which are relevant in the context of this Review. Whilst not all are explicitly mentioned in this Issues Paper, this Review is aware of these important pieces of work and where appropriate, relevant policies, strategies and reviews have been cross-referenced (for example, the National Digital Health Strategy 2023-2028 and Strategy Delivery Roadmap).

The purpose of this Issues Paper is to provide an overview of the evidence collected to date through evidence review, submissions and consultations, to outline the options for reform based on the sum of this evidence, pose questions for further exploration through the next phase of consultations, and describe the direction and next steps for the Review. This document provides:

- a concise summary of evidence gathered to date;
- a summary of reform options based on evidence gathered to date;
- discussion questions to guide Phase 3 consultations.

Additional relevant information regarding the Review can be found on the Review website, including [Issues Paper 1](#).

## 2. The journey

### Phase 1 consultation

Phase 1 of the Review consultation was undertaken in September-December 2023. More than 700 submissions to targeted questions focused 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, enablers, benefits and risks to health professionals working to full scope of practice and how these barriers could be overcome.

### Issues Paper 1

The first Issues Paper provided an overview of policy issues through a review of the evidence, submissions provided to the Review team and the first round of consultation. Themes emerging from these sources were outlined along with areas that required further exploration. Specific questions were posed regarding issues identified as requiring further discussion and feedback.

Five themes emerged from the first round of consultation:

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 and payment policy** – the way funding and payment is provided for delivery of health care;
5. **Technology** – integrated and accessible digital tools, communication and information sharing.

### Phase 2 consultation

The second phase of consultation was undertaken between 23 January and 8 March 2024, and generated feedback from a range of perspectives on the emerging themes raised in Issues Paper 1. Consultations occurred via a public submissions portal (the Citizen Space portal), face-to-face workshops across Australia, virtual workshops and targeted stakeholder meetings. A total of 161 submissions were received via the Citizen Space portal and 86 via email. Consultations were attended by over 500 participants, across 19 face-to-face sessions and 3 targeted virtual sessions for consumers and rural and remote stakeholders.

During Phase 2 consultations, stakeholders were asked to provide feedback regarding a range of reform options developed in response to the findings of Phase 1 consultation. Stakeholder views were examined for the relative level of support presented across each of the proposed policy solutions; key areas of convergence, divergence and interdependency; and any emerging themes or policy solutions which did not appear in Issues Paper 1. Further consultation was undertaken to strengthen the representation of First Nations and consumer perspectives.

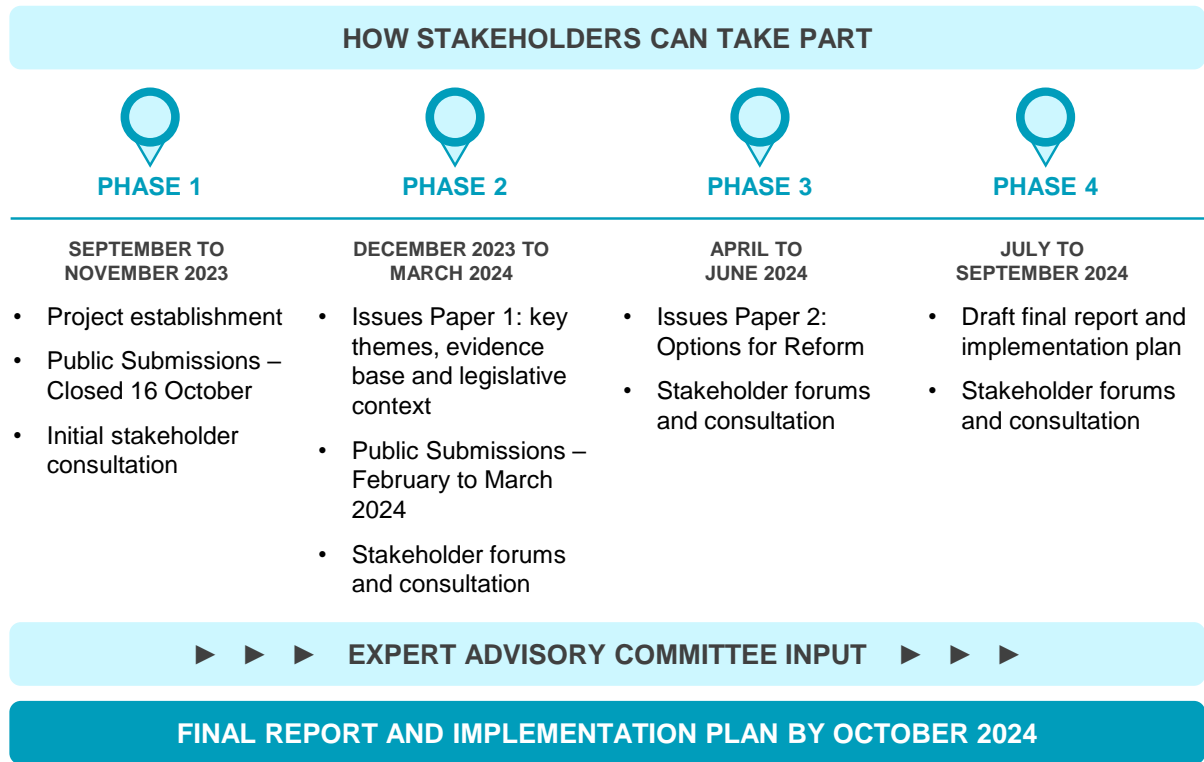


Targeted consultation with a range of stakeholder groups, including jurisdictions and Commonwealth officials was also undertaken throughout March. This consisted of feedback of findings from Phase 2 consultation and testing of emerging themes.

The feedback received during Phase 2 consultations has been synthesised with other evidence to produce this Issues Paper, which explores the specific policy and system reforms available to address identified barriers associated with health professionals working to full scope of practice.

The Review will continue to gather feedback in Phases 3 and 4, as illustrated in [Figure 2](#).

**Figure 2: Phases of the Review and how stakeholders can take part**



## Evidence Review

A review was undertaken to explore the available evidence that considered the value (or not) of health professionals working to full scope of practice in primary care. Informed by the five focus areas highlighted in the Phase 1 consultation, and described in Issues Paper 1 (legislation and regulation, employer practices and settings, education and training, funding and technology), the evidence review considered four key questions:

- What works, for whom, in what circumstances and why?
- Which social and cultural resources are necessary to sustain the changes?
- What is it about the initiative which might produce change?
- Which individuals, groups and locations might benefit most readily from the initiative?

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.

The evidence review methodology included a systematic search of published and grey literature. Five health-science databases were searched to identify literature published between 1 January 2000 and 31 December 2023. A three-phase strategy was employed to search grey literature involving subject matter experts, replication of the database search using tracking software to highlight relevant sources of information, and a targeted advanced Google search. Specific criteria informed the screening and extraction of relevant articles which was supported by Covidence<sup>11</sup> software.

International best practice case studies were also explored under the focus areas listed above using a Context-Mechanism-Outcome approach associated with realist evaluations that enabled recognition of the social, political, cultural and other contexts that influence how effective policy and practice change are achieved. The evidence review reflected how this context may be similar or different to the Australian experience, and therefore which elements of this evidence could be applied.

The findings of the evidence review will be described further in [3a. Key findings from Phase 2](#).

## Legislation and regulation review

In parallel with the above, a review was undertaken of legislation and regulation which impacts scope of practice either directly or indirectly. The objective of this review was to identify the key material barriers in the existing legislative regime across Australia to health professionals working to full scope of practice. The review specifically sought to identify a shortlist of regulatory matters considered to have the greatest impact on scope of practice, and which if amended, would be likely to have the greatest positive impact. Subject to detailed review were:

1. Identification of a longlist (see [Appendix A – Part 2](#)) of all legislative and regulatory subjects which directly or indirectly limit primary health care scope of practice (either purporting to limit scope or having a practical impact on scope of practice) and testing against findings from stakeholder consultations to identify the areas of legislation with potentially the most significant practical impacts on scope of practice (using the *Pareto principle*).
2. High level review of selected areas of legislation to ascertain likely impact on scope:
  - a. Health Practitioner Regulation National Law Act 2009 (Health Practitioner National Law, as applied in each state and territory);
  - b. Drugs and poisons legislation in each jurisdiction;
  - c. Mental health legislation in each jurisdiction; and
  - d. Commonwealth MBS funding legislation.
3. A review of the Health Practitioner National Law revealed that, despite some variation in its application between jurisdictions, it broadly acts as an enabler of scope of practice.

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<sup>11</sup> Covidence Veritas Health Innovation Ltd. Available from: <https://www.covidence.org/>

The parallel review of the mental health legislation in each jurisdiction revealed that it is not likely to be a primary impact on scope at the primary health level.

4. In light of the above finding, the review turned to targeted mapping and analysis of the following areas of law, which were identified to have the most substantial impacts out of the Pareto group identified:
  - a. The Health Insurance Act 1973 (Cth) and associated legislative instruments; and
  - b. State and territory drugs and poisons regulations
5. Detailed mapping of all state and territory drugs and poisons regulations was undertaken to indicate areas of inconsistency and to ascertain how references to the National Law may have a (practically) limiting impact on scope of practice.
6. A targeted review of the Health Insurance Act 1973 (Cth) and associated legislative instruments (regulations and determinations) to validate hypotheses developed through analysis of Phase 2 evidence. This review had a particular focus on:
  - a. Limitations on which health professionals can refer patients to other health professionals or request pathology or imaging for patients under the MBS;
  - b. Ability of nurses to deliver mental health care services in the community under the MBS; and
  - c. Inconsistencies in the fees prescribed for MBS services undertaken by different health professionals.

A summary of mapping is available in [Appendix A](#).

## 3. What we've learned

This section summarises the key evidence drawn to date from a range of sources, with particular focus on analysis of the Phase 2 consultation findings, the evidence review and legislation and regulation review.

### 3a. Key findings from Phase 2

Analysis of the second round of consultation findings, combined with evidence review findings, reinforced the barriers to enabling primary care professionals to work to their full scope of practice. Barriers were identified as having tangible impacts across the themes, including:

- **Reduced workforce mobility and skills portability**, resulting from inconsistent recognition of professional scope and/or qualifications gained through post-entry education, training and experience.
- **Poor workforce retention**, with inability to work to full scope identified as a strong influence on health professionals choosing to leave the health workforce.
- **Restricted consumer access to optimal care**, particularly for consumers living in regional and remote areas. This was highlighted where a health professional is available, but not authorised or enabled to provide care that falls within their scope.
- **General Practice workload, productivity and scope impact** associated with other health professionals being unable to work to their full scope of practice.
- **Reduced opportunity for multidisciplinary care**, due to barriers restricting health professionals from working collaboratively as a multidisciplinary team and reinforcing professional siloes.

Within the five themes that emerged from the first round of consultation, several policy solutions were posed for feedback during the Phase 2 consultation period. The below sections summarise the combined evidence from stakeholder perspectives in response to the proposed areas for reform, and findings from the evidence review.

#### *Legislation and Regulation*

Legislation and regulation were acknowledged as fundamentally shaping scope of practice. Stakeholders identified overly restrictive or specific legislation as a significant impediment to primary care professionals working to their full scope. Inconsistencies in legislation were noted between states and territories with a resultant impact on workforce mobility, skills portability and consumer access to care. Jurisdictional differences were also viewed as confusing, impacting consumer and health professional understanding of practice scope. Stakeholders strongly supported harmonising drugs and poisons legislation, and suggested this should be considered a priority reform.

Regulation according to named professions was viewed by many as constraining scope of practice. Highly prescriptive legislation and regulation were widely observed as indirectly limiting scope of practice, and in doing so, working against the enabling intent of the National Registration and Accreditation Scheme (NRAS) and the National Law. Strong support was provided, particularly from non-medical professions and those practising in regional and

remote areas, for an alternative, risk-based approach to regulation as a mechanism to support full scope of practice. Opposition to this proposed change was provided by those who considered protected titles as providing an element of safety not identified in a risk-based approach.

The self- and unregulated workforces sought greater acknowledgement of the regulatory differences that impact their practice when compared to the professions governed by the Health Practitioner Regulation National Law (the National Law) as part of NRAS. The importance of considering legislative and/or regulatory solutions that would enable these workforces to work to their full scope was highlighted, although clear consensus regarding how this would be operationalised was not reached.

Professional Indemnity insurance was commonly described as an issue impacting scope of practice. There were concerns indemnity coverage did not always align with existing scope of practice and that issues may arise from attempts to enable health professionals to work to their full scope of practice. Moreover, in the context of delegation, concerns were raised that liability risk would shift between health professionals working in multidisciplinary care teams, highlighting the complexity of indemnity arrangements in primary health care settings.

These views reflect evidence that describes the necessity to better align indemnity with scope of practice, and that restrictive scope of practice laws increase the liability risk faced by physicians.<sup>12 13</sup> Literature also indicates that health professionals are less likely to be deterred from unsafe practice when under mandatory supervision by a medical practitioner, suggesting health professional behavioural change in relation to indemnity depends on their supervisory arrangement. This finding further emphasises the importance of separate and fulsome indemnity coverage for all members of the multidisciplinary care team.<sup>14</sup>

*"We have skilled nurses who can't do skin checks in rural areas because indemnity won't cover them, because of the risk they'll miss something - it's ludicrous because it's a choice between no skin checks or skin checks by a trained person, but we weren't able to let that nurse perform that task." – Melbourne consultation participant*

### Insights from evidence review

The views expressed during consultation align with the evidence review, which highlighted the utility of a risk-based approach to regulation of scope as a complement to protected titles or named professions as a mechanism to authorise health professionals to work to their full scope of practice. This was most prominent in the example of an umbrella framework applied in Canada, which recognises skills and competency areas across professions, rather than tied to titles. This has enabled a collaborative care model with task sharing possible based on health professional availability, consumer preference or other factors.

<sup>12</sup> Scott, F. (2010). Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional. [online] Accessed from:

[https://assets.publishing.service.gov.uk/media/5a75bf77e5274a4368299aa3/dh\\_117457.pdf](https://assets.publishing.service.gov.uk/media/5a75bf77e5274a4368299aa3/dh_117457.pdf).

<sup>13</sup> McMichael, Benjamin J.. "Shifting Liability with Licensing: An Empirical Analysis of Medical Malpractice and Scope-of-Practice Laws " *Journal of Tort Law*, vol. 12, no. 2, 2019, pp. 213-253. Accessed from: <https://doi.org/10.1515/jtl-2019-0028>

<sup>14</sup> Ibid

## *Employer practices and settings*

Health professionals identified inconsistent recognition of qualifications across employers and health settings as a significant barrier to full scope practice, potentially also impacting professional satisfaction. Trust between team members was frequently highlighted as essential for primary care teams. Clear recognition of qualifications, skills and capabilities was also identified as important to contribute to trust within teams, highlighting the significant level of crossover and interdependency between this theme and Education and Training.

Clear support was provided for greater consistency in the recognition of qualifications across jurisdictions, employers and healthcare settings, as an important mechanism to facilitate strong team function and contribute to workforce mobility and improved professional satisfaction.

Stakeholders supported primary care provided by multidisciplinary teams comprised of the health professionals who will most effectively meet consumer need. However, the multiprofessional team model may be unsupported by existing funding and payment policy settings that currently restrict funding to certain professions. Multiprofessional teams may be required to work across employers. Stakeholders highlighted the need for consistent recognition of health professional skills and capabilities to enable teams to work in this way.

In enabling health professionals to work to full scope, the importance of ensuring patient safety was acknowledged. Strong clinical governance was identified as providing important structural strength for primary care teams and to ensure both quality and safety in service provision.

*“The ‘dilly bag’ analogy [means] the team you have in remote community will be based on the needs of community, whereas currently it is based on how many physios NT Health has ... it's rationed, not based on need.” – Darwin consultation*

*“Priority must be given to the most accessible and safest outcome for patients; not professional competition or monopoly by one health provider over another to perform activities that can be safely performed by either practitioner as it falls within their scope of practice.” - Email submission*

### Insights from evidence review

Consistent with consultation feedback, evidence indicates that dispersed employment settings within Australian primary care affect the establishment and growth of new workforces. For example, the uptake of allied health assistant roles has been markedly slower in Australia compared to the UK, in part due to differences in employment models between the countries. The National Health Service, as the single employer, can implement change more effectively compared to the predominantly small business contractor and employment model operating in Australia<sup>15</sup>.

Reduced access to midwifery care and underutilisation of this workforce in the USA is associated with a high rate of caesarean births and disproportionately high maternity mortality. State-based regulations affect the midwifery workforce, however practice is also affected by licensing and administrative issues, institutional practices, cultural factors and resistance from medical professionals<sup>16</sup>. Institutions with high interprofessional communication have been found to have less complications and readmissions<sup>17</sup>, as well as improved midwife satisfaction<sup>18</sup>.

### Education and training

The skills required to practise collaboratively are frequently developed in entry-level programs. For all regulated professions, accreditation standards require interprofessional education. However, inconsistencies exist in how these standards are applied across professions. Stakeholders considered greater consistency in interprofessional education important. Consistent with this, stakeholders supported multi-professional learning in primary care where health professionals learn together to support their practice.

Experiential learning was identified as important to develop the skills required to practise in primary care. The need to fully support this process, both in a supervised capacity in entry-level programs, and using mentors in the post-entry period was expressed as important to contribute to professionals being able to work to their full scope.

Despite a mature, nationally consistent and transparent health professional regulation model, inconsistencies were identified in the ability of health professionals to fully utilise the skills they have developed through post-entry education and training. Qualifications may not be fully understood or valued by employers, leaving the health professional unable to perform roles for which they are competent, or requiring them to complete additional education, training or credentialling. In some cases, post-entry qualifications are titled differently across

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<sup>15</sup> Nancarrow, S. and A. Borthwick (2021). The support workforce within the allied health division of labour. The Allied Health Professions, Policy Press: 131-150.

<sup>16</sup> Kleinpell, R., Myers, C. R., & Schorn, M. N. (2023). Addressing Barriers to APRN Practice: Policy and Regulatory Implications During COVID-19. *Journal of Nursing Regulation*, 14(1), 13–20. Accessed from: [https://doi.org/10.1016/S2155-8256\(23\)00064-9](https://doi.org/10.1016/S2155-8256(23)00064-9)

<sup>17</sup> Neal, J. L., Carlson, N. S., Phillippi, J. C., Tilden, E. L., Smith, D. C., Breman, R. B., Dietrich, M. S., & Lowe, N. K. (2019). Midwifery presence in United States medical centers and labor care and birth outcomes among low-risk nulliparous women: A Consortium on Safe Labor study. *Birth*, 46(3), 475–486. Accessed from: <https://doi.org/10.1111/birt.12407>

<sup>18</sup> Thumm, E. B., Smith, D. C., Squires, A. P., Breedlove, G., & Meek, P. M. (2022). Burnout of the US midwifery workforce and the role of practice environment. *Health Services Research*, 57(2), 351–363. Accessed from: <https://doi.org/10.1111/1475-6773.13922>

jurisdictions, contributing to poor recognition of skills. National consistency in common post-professional entry qualifications was supported.

Education and training that develops common capabilities was identified as inconsistent across jurisdictions and/or professions, impacting health professional and consumer understanding of scope expectations. For example, the skillsets required for vaccination, insertion of intravenous cannulas, catheter management and basic life support are common to multiple professions however, the training to develop these skills differs across jurisdictions, education providers and professions. This is compounded where different titles are applied to similar qualifications. A consequence may be that health professionals are required to complete duplicate education and training to undertake their role. National consistency in the education and training for capabilities required by multiple professions was viewed as essential to support primary care teams.

Supporting consumer understanding of health professional qualifications, and how this impacts their scope, was considered important to enable informed choices regarding care.

### **Insights from evidence review**

International evidence aligned with the Australian experience highlighted during consultation. State regulatory and legislative restrictions, including state licensing in the USA, were identified as impeding the ability of health professionals to work to full scope of practice despite nationally standardised curricula. Credentialling and privileging enacted at a local service or facility level, were experienced in a similarly inconsistent way to Australia.

Interprofessional education programs for skillsets shared by multiple professions have provided clear benefits in preparing students to work on defined health issues and address workforce distribution issues, as well as work more collaboratively.

### **Insights from consultation**

Examples of multi-professional learning discussed during consultation include:

- Pre- and ante-natal care provided by midwives, obstetricians, general practitioners and lactation consultants.
- Community-based care for musculoskeletal issues provided by physiotherapists, podiatrists, chiropractors, osteopaths and exercise physiologists.
- Mental health care provided by psychiatrists, psychologists, mental health nurses, social workers, counsellors and peer workers.

## **Funding**

The importance of funding mechanisms in shaping health professional scope of practice was acknowledged by stakeholders. Funding reform was considered important to affect real change in the provision of primary care by health professionals who are supported to practise to their full scope.

Stakeholders welcomed funding models that support the multidisciplinary care team. Payment for care co-ordination (i.e., non-patient facing tasks) was considered important to contribute to team collaboration. Complexities were highlighted, however, in identifying funding mechanisms able to support professionals practicing across locations who provide care for the same patient.



Flexible funding arrangements that enable the delivery of primary care tailored to community need was supported by the majority of stakeholders. Block, bundled, blended and salaried funding models were discussed, although no clear consensus was reached regarding the most effective model. Block funding, either alone or as a component of an overall funding arrangement, was viewed as contributing a range of benefits, including facilitating better care for complex needs, improving continuity of care, providing flexible healthcare teams and improving team collaboration.

Current funding mechanisms were noted to disincentivise some, particularly non-medical, health professions from contributing to primary care teams, due to the inability to access fee-for-service arrangements. Proposed amendments to existing MBS funding rules that would enable direct referrals between professions and the provision of referrals for patients to access diagnostic procedures, were viewed as a priority by many, but not all, stakeholders.

The majority of stakeholders supported a single payment rate for the same activity, regardless of profession, although this was not unanimously supported by medical practitioners.

### **Insights from consultation**

A representative of a Tasmanian after-hours nurse-led service described how they maintained a multidisciplinary care team through a blended funding model: partially funded by the state government to enable salaried staff, including a community paramedic, while the nurse practitioner bills via the MBS.

“There could be opportunity for the health sector to move more towards a mix of bundled and salaried models, with fee-for-service being reserved for some health services where appropriate.” – Survey response

### **Insights from evidence review**

Evidence demonstrated that the dominant fee-for-service funding model in Australia is most appropriate for simple, episodic care or where a high volume of service is required. For chronic conditions where multidisciplinary, team-based approaches are required, fee-for-service tends to result in reactive and fragmented care<sup>19 20 21</sup>. Other research suggests fee-for-service creates a focus on service volume that leads to short consult times, excessive referrals and lack of attention to patient preferences<sup>22 23</sup>.

International evidence reinforces that alternative funding models support health professional integration in primary care and working to full scope. For example, capitation in New Zealand has fostered increased involvement of nurses in primary health care delivery<sup>24</sup>.

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<sup>19</sup> Angeles, M. R., Crosland, P., & Hensher, M. (2023). Challenges for Medicare and universal health care in Australia since 2000. *Med J Aust*, 218(7), 322-329. Accessed from: <https://doi.org/10.5694/mja2.51844>

<sup>20</sup> Duckett, S., Swerissen, H., and Moran, G. (2017). Building better foundations for primary care. Grattan Institute.

<sup>21</sup> OECD (2015), *OECD Reviews of Health Care Quality: Australia 2015: Raising Standards*, OECD Reviews of Health Care Quality, OECD Publishing, Paris, Accessed from: <https://doi.org/10.1787/9789264233836-en>.

<sup>22</sup> Oliver-Baxter, L., & Brown, L. (2013). Primary health care funding models. *PHCRIS Research RoundUP* (33).

<sup>23</sup> Wranik, D. W., & Durier-Copp, M. (2010). Physician remuneration methods for family physicians in Canada: expected outcomes and lessons learned. *Health Care Anal*, 18(1), 35-59. <https://doi.org/10.1007/s10728-008-0105-9>

<sup>24</sup> Adams, S., & Carryer, J. (2023). The Evolution and Future of Nurse Practitioners in New Zealand. In *Nurse Practitioners and Nurse Anesthetists: The Evolution of the Global Roles* (pp. 255-262). [https://doi.org/10.1007/978-3-031-20762-4\\_19](https://doi.org/10.1007/978-3-031-20762-4_19)



## Technology

Stakeholders were supportive of certain technology solutions to support full scope of practice. Access to real-time patient information had strong support in principle, as did platforms for secure messaging and digital referrals, each of which were seen as ways to increase visibility over the scope of practice of the multidisciplinary care team, and associated interprofessional trust and understanding.

However, technology solutions overall were viewed as an enabler of other, overarching directions for reform rather than solutions to enhance scope of practice in their own right. As such, they are referred to throughout this paper as enablers of specific reform options.

An ongoing body of work through the National Digital Health Strategy to strengthen digital technologies underpinning the primary health care system will support the directions for reform outlined in this Issues Paper, and has been referenced as such as an important interdependent suite of reform.

## Benefits of full scope of practice

**Consultation** participants highlighted a range of benefits they believe would flow from enabling health professionals to work to their full scope of practice. Broadly these align with the quintuple aim of healthcare improvement<sup>25</sup> which includes:

- **Improving population health** by supporting health professionals to work safely and effectively.
- **Reducing healthcare costs** by increasing team-base efficiencies.
- **Enhancing care experiences** by improving healthcare accessibility.
- **Improving the experience of healthcare professionals** by enabling health professionals to do the roles they are competent and trained to do.
- **Advancing health equity** by enabling health professionals to work to their full scope particularly in areas that service vulnerable populations.

**The evidence review** identified several key findings that correlate with the quintuple aim of healthcare improvement when health professionals are supported to work at full scope of practice:

- Evidence of **improved access to care** through longer consultations, more information sharing, and appropriate care utilisation across professions like nursing, midwifery, pharmacy, physiotherapy.
- Evidence of **equal or better outcomes** in areas like chronic disease management, mental health and prescribing.
- Evidence of **cost savings**, with some studies showing lower total costs and prevention of unnecessary services.

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<sup>25</sup> Itchhaporia, D. (2021). The evolution of the Quintuple Aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology*, 77(18), 2262-2264. <https://doi.org/10.1016/j.jacc.2021.03.191>

- Evidence of **increased access** in rural/remote and medically underserved areas, and moderately improved workforce maldistribution in the short-term.

Overall, the direct evidence for impact on clinician wellbeing for scope of practice was limited, but there was a clear interest from professions seeking more ability to contribute to patient care. There is a pressing need for more research investigating health professional wellbeing, and how culturally safe care and equitable health outcomes can be achieved through an optimised workforce.

### 3b. Alignment with legislative and regulation review findings

Hypotheses developed by considering the above evidence were broadly confirmed by the review of legislation and regulation. As summarised above, the targeted review of legislation and regulation focused on two key subjects which were determined through analysis to have the most material impact on scope of practice: the Health Insurance Act and associated legislation instruments, and state and territory drugs and poisons legislation.

In the initial stages of the legislative and regulatory review, a longlist of legislative and regulatory subjects likely to have an impact on primary health care scope of practice was developed (see [Appendix A – Part 2](#)). In undertaking the review, it was recognised that the issues relating to the Health Insurance Act and associated legislation instruments, and state and territory drugs and poisons legislation were likely to reappear in other subjects of legislation and regulation for which detailed mapping had not been undertaken. That is, while the aforementioned two subjects were the primary focus for review, there was evidence suggesting that the challenges identified were more widespread across legislation and regulation in the longlist (i.e., high levels of specificity in legislation, inconsistent approaches to legislation or regulation between jurisdictions, use of named professions) with a limiting impact on scope.

Key findings corresponding to the above evidence are summarised below.

#### ***Review of Health Insurance Act and associated legislative instruments***

A review of the *Health Insurance Act 1973* (hereafter ‘Health Insurance Act’) determined that it, and its associated legislative instruments (regulations and determinations), have a significant (practical) impact on scope of practice, corresponding with evidence heard about the extent to which MBS funding regulation practically impacts health professionals’ scope of practice. Because the Health Insurance Act and associated legislative instruments are highly specific about the circumstances under which, and to whom, MBS funding can flow, they have a highly restrictive impact on health professionals’ practical ability to work to their full scope of practice.

**While the Health Insurance Act and associated regulations are not primarily intended to regulate scope, they are so highly prescriptive about what can be funded and who can access MBS-funded services, that they have a significant practical impact on what primary health care professionals can practically deliver.**

This review included a consideration of which health professionals are empowered to refer patients to other health professionals for MBS-funded services and to request MBS-funded pathology or imaging for patients. The findings indicated a significant degree of specificity: a highly constrained group of health professionals can make referrals to highly specific types of specialist services as a condition for the consumer to access the MBS rebate. Moreover, a review of associated funding regulations under the Health Insurance Act found there is significant disparity between MBS rates for different professions for broadly comparable services, notwithstanding that a direct comparison between services performed by different health professionals was not possible in all cases.

The practical impact of the MBS funding arrangements set out under the HIA is to limit the extent to which health professionals can practise to their full scopes as broadly enabled under the Health Practitioner Regulation National Law Act 2009 (hereafter 'National Law'), as applied in each state and territory.

### **Review of Drugs and Poisons legislation**

Despite all states and territories ascribing to a consistent policy intent in developing their respective Drugs and Poisons legislation and adopting the national Poisons Standard made under the Commonwealth Therapeutic Goods Act 1989, there is significant definitional variation between state and territory legislation. This results in confusion about what it means to deal with drugs and poisons in different states and territories, and, in some instances, in the same profession having different authorisations under different state and territory legislation. The complexity created by these inconsistencies creates confusion around what health professionals are authorised to undertake when working across different states and territories. States' and territories' respective Drugs and Poisons Acts are, substantively, silent on references to self-regulated professions. This is due largely to how these Acts define the term 'health practitioner' with reference to the National Law, therefore precluding self-regulated professions from the definition and, consequently, from having legislative authority to deal with Drugs and Poisons in each jurisdiction. Self-regulated professions may have limited (if any) recourse to authorisation by alternative means (such as being licensed by the relevant Minister in each jurisdiction) to perform certain functions in respect of drugs and poisons in limited circumstances, but there is no catch-all authority available to them under legislation.

## **3c. Emerging directions for reform**

The evidence reviewed, combined with the consultation findings, have been distilled into a series of reform options, designed to address the policy problems and potential solutions identified during Phase 2.

The options for reform sit under three themes, condensed from the original five themes arising from Phase 1. This distillation acknowledges the level of interdependency and overlap between Phase 1 themes (such as between education and training and employer practices and settings) and the way aspects of some themes (such as technology) act as an important enabler of other themes. It is intended that the policy reform options combine to enable full scope of practice at the individual, team and systems levels.

The reform options require the support of strong clinical governance and leadership and a cultural shift that embraces health professionals working to their full scope. The table below summarises the reform options which are presented in detail in the following section.

Table 1: Emerging directions and options for reform

Theme	Policy problem	Option for Reform
<b>Workforce design, development and planning</b>	<p>Poor recognition of primary care health professional skills and capabilities impedes interprofessional trust, multidisciplinary team-based care and effective health workforce planning</p> <p>Limited focus on primary care in the entry-level curriculum and poor support for health professionals impedes their ability to develop skills specifically required for primary care</p> <p>Poor support for early career health professionals and inconsistencies in post-entry education and training impede health professionals' ability to develop primary care skills post-professional entry</p>	<ol style="list-style-type: none"> <li>1. <b>National Skills and Capability Framework and Matrix</b> to improve understanding of health professional skills and capabilities and establish a basis for workforce planning.</li> <li>2. <b>Develop primary health care capability</b> to equip health professionals to practise effectively to full scope of practice.</li> <li>3. <b>Early career and ongoing professional development, includes multiprofessional learning and practice</b> to maintain primary care skills and support the team to work together effectively.</li> </ol>
<b>Legislation and regulation</b>	<p>Highly restrictive regulation indirectly limits scope of practice</p> <p>Legislation and regulation are not adequately responsive to emerging evidence or innovation in scope of practice</p> <p>Inconsistency between state and territory Drugs and Poisons legislation impacts consistency of scope of practice between jurisdictions</p>	<ol style="list-style-type: none"> <li>4. <b>Risk-based approach to regulating scope of practice to complement protection of title approach</b> to enable health professionals to more consistently work to full scope of practice.</li> <li>5. <b>Independent, evidence-based assessment of innovation and change in health workforce models</b> to inform legislation and regulation and enable contemporary best practice.</li> <li>6. <b>Harmonised Drugs and Poisons regulation to support a dynamic health system</b> by providing consistency and clarity between states and territories.</li> </ol>

<b>Funding and payment policy</b>	<p>Primary health care funding and payment models do not support health professionals to work at full scope multidisciplinary care teams</p> <p>MBS payment rules and inadequate digital infrastructure restrict of health professionals' need to make direct referrals within their scope.</p>	<p>7. <b>Funding and payment models that incentivise multidisciplinary care teams working to full scope of practice</b> to support the primary health care team.</p> <p>8. <b>Direct referral pathways supported by technology</b> that enable health professionals to make referrals within their scope and to improve access to care for consumers.</p>
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## 4. Options for reform

This section outlines options for reform as developed through evidence gathered to date. These have been developed in response to consultation held during Phase 2.

Each option for reform details a summary of the policy issue, options for policy reform and potential implementation mechanisms, intended outcomes and stakeholder impacts, potential challenges and risks associated with implementation, and an indication of how success would be measured. The Review will continue to consult key stakeholders to obtain feedback and refine the options for reform to ensure they meet the needs of the community. Questions for further consultation are included throughout and will form the basis for further consultation in Phase 3.

Key emerging cross-cutting themes are detailed below for consideration across all options for reform. Throughout options for reform, implementation timeframes are indicatively given as:

- **Short-term:** less than 2 years
- **Medium-term:** 2-5 years
- **Long-term:** 5+ years

### *Leadership and culture*

Workplace and professional culture have a profound effect on the ability to achieve reforms designed to enable health professionals to work to their full scope of practice. Consultation highlighted the significant role the culture of a workplace or profession plays in supporting change and contributing to safe and effective team-based care. Consistent with this, a positive culture between professions was viewed as important within primary care teams.

Stakeholders consistently indicated support for primary care provided by teams working to their full scope of practice. Workplaces and professions characterised by a culture of inclusivity and trust, particularly where professions intersect in the provision of care, were highlighted as providing better team-based care, compared to those that practise according to professional siloes. Similarly, individuals who recognise their scope boundaries and adopt a culture that seeks collaboration with other team members to meet patient need, were viewed as contributing to the delivery of safe and effective team-based primary care.

Leadership within primary care drives culture and change. The evidence review describes the complex system that influences scope of practice in addition to the factors that impact personal scope of practice, including legislative and regulatory mechanisms, profession-specific practice expectations and site-specific requirements. It is impractical for individuals to verify the capabilities of their colleagues within a team-based structure, leaving it necessary to trust the ability of team members to recognise and react to personal scope boundaries. This trust is facilitated by a clear understanding of the scope of professional colleagues. Leadership at all levels, that facilitates and drives collaboration and scope recognition, is important to allow health professionals to practise to their personal full scope of practice.

The success and sustainability of genuine reform rests on a clear vision for an improved primary care and a long-term commitment to achieving this aim. Consistent with this vision,

strong leadership is essential at all levels, and particularly in areas responsible for policy decision-making. Without an agreed vision, coupled with sustained commitment to achieve reform, true change is subject to many factors that potentially impede success.

The reform options presented in this paper have a bidirectional relationship with culture and leadership. The proposed reforms will influence, and be influenced by, the culture of a workplace/professional and the leadership shown within a workplace and/or profession.

Culture and leadership more broadly extend to cultural safety. Aboriginal Community Controlled Health Organisations (ACCHOs) were frequently raised through consultation as an example of existing best practice from which the broader primary health system could learn. Key areas where the mainstream primary health system could learn from approaches taken within ACCHOs were the multidisciplinary and whole-of-person approach to delivering primary health care, and comprehensive guidance exemplified by the NACCHO Core Services and Outcomes Framework (which applies in a place-based way across ACCHOs). However, discrimination and lack of cultural safety were raised as significant barriers for First Nations people working in primary health care settings, including Aboriginal Health Practitioners.

*“Models that work for First Nations people in ACCHO setting (whole of person) can be replicated in mainstream settings. The Indigenous medical workforce experiences racism and discrimination at a much greater rate and it’s increasing. We need some authorising oversight there so we can maintain a happy and healthy workforce... multidisciplinary teams need to be financially viable and this cohesiveness will attract workforce.” – First Nations consultation participant*

*“More inspiration could be taken from models adopted in Aboriginal Community Controlled Health Organisations (ACCHOs) which address wraparound care needs and often utilise combined salaried models and Medicare billing. However, caution should be taken to not create considerable administrative complexity and reporting burden when combining funding streams.” – Survey response*

## **Clinical governance**

Sound clinical governance mechanisms that combine to systematically review and improve the quality of care are fundamental to healthcare excellence.

Recognising what quality care looks like is an important initial step. Ensuring safe, effective and efficient care requires the primary care professional and team to understand and comply with expected standards of practice, recognise and trust scope boundaries (own and team members) and commit to the delivery of patient-centred care. Structural mechanisms within the healthcare system are essential to enable the individual professional, and the primary care team, to function optimally and meet the needs of the community. Safety assurance mechanisms need to effectively and efficiently capture and manage instances where this does not occur and directly influence quality improvement processes.

Understanding what health professionals do and how they practise are important contributors to functional primary care teams. Evidence provided by stakeholders during consultation highlighted a need to improve the understanding of, and trust in, health professional scope within primary care teams. A clearer understanding of *what* health professionals do is important to improve team function. Similarly, a better understanding *how* health



professionals undertake their clinical roles, recognising the different lens through which professionals view care, may contribute to team cohesiveness. Stakeholders highlighted that strong, cohesive teams utilise governance mechanisms such as opportunities to reflect on, and learn from, care experiences to contribute to ongoing quality improvement.

Primary care in Australia functions across a range of settings and is frequently characterised by individual professionals practicing in separate locations. The challenge of supporting primary care professionals to develop a deeper understanding of their colleagues' scope is confounded by the distance that commonly sits between them. Consequently, the support required to strengthen quality primary care teams will look different across settings.

These factors are highlighted in the following options for reform. [Option 1: National Skills and Capability Framework and Matrix](#) provides a pathway to support skill recognition at a national level. This aims to improve the visibility of health professional skill and support an enhanced understanding for consumers, health professionals and primary care teams. Options for reform [Option 2: Develop primary health care capability](#) and [Option 3: Early career and ongoing professional development includes multi-professional learning and practice](#) aim to improve the understanding and trust between primary care professionals and the cohesiveness and function of the primary care team by facilitating an improved understanding of how health professionals work together. These reform options highlight the importance of interprofessional education and multi-professional learning experiences. [Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice](#) supports health professionals to develop trust and collaborative skills by enabling teams to work more closely in the delivery of care.

In addition to the reform options highlighted above, and provided in more detail in the following sections, consideration should be given to compulsory compliance with the National Safety and Quality Primary and Community Healthcare Standards<sup>26</sup>.

## ***Rural and remote considerations***

In rural and remote areas, the impact of issues relating to scope of practice were determined through the evidence to be overall more profound, due to issues of workforce constraints, distance, and specific local community needs. As well, stakeholders from rural and remote regions also indicated the appetite for innovation and reform was found to be overall higher in these regions.

These factors make rural and remote regions an appropriate setting for localisation and applications of reform options, and a key priority for implementation. This consideration applies across the following reform options, with options to progress a rural and remote 'launch pad' for specific reform to be explored.

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<sup>26</sup> Australian Commission on Quality and Safety in Health Care. National Safety and Quality Primary and Community Healthcare Standards. Sydney: ACSQHC; 2021 Accessed from: [https://www.safetyandquality.gov.au/sites/default/files/2021-10/national\\_safety\\_and\\_quality\\_primary\\_and\\_community\\_healthcare\\_standards.pdf](https://www.safetyandquality.gov.au/sites/default/files/2021-10/national_safety_and_quality_primary_and_community_healthcare_standards.pdf)



## 4a. Workforce design, development and planning

Options for reform developed in relation to education and training are:

- Option 1: National Skills and Capability Framework and Matrix.
- Option 2: Develop primary health care capability
- Option 3: Early career and ongoing professional development includes multi-professional learning and practice

**The first reform option, development of a National Skills and Capability Framework and Matrix, is assumed to be foundational for all other reform options.**

**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 practise their health profession or undertake that activity.

**Registration:** Formal approval for a person to practise 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.

**Supervised Practical Training:** A required period of practical training completed in the workplace under supervision to provide context relevant experiential learning opportunities.

## Option 1: National Skills and Capability Framework and Matrix

### Summary

Consultation highlighted that primary care health professionals commonly have a limited understanding of their colleagues' potential full scope of practice. The same lack of understanding of scope of practice applies to employers and consumers. This was identified as reducing the ability of health professionals to recognise and trust the skills of other members of the primary care team, potentially impeding overall team function. While individual health professionals can modify their scope of practice according to professional experience and post-qualification education and training, recognition of the broad skills a health professional is equipped with at entry to practice is important to broaden the understanding of health professional scope of practice.

#### **Issue 1: Poor recognition of primary care health professional skills and capabilities**

Poor recognition of the skills and capabilities of primary care health professionals undermines interprofessional trust and impacts the ability of primary care teams to respond to community need. In parallel, poor skill recognition impacts the individual health professional and may reduce professional satisfaction and potentially impede staff retention.

#### **Insights from consultation**

Stakeholders described challenges in understanding the scope of professional colleagues as well as frustration at not being recognised for the skills they have. Consumers indicated trust in health professionals to provide quality care.

*"[For] Postgraduate studies – [We are] missing a matrix outlining scope of practice for all professions and the Venn diagram of where the intersections are – understanding everyone's scope of practice.... Don't be fearful of the overlap of scope – and put the patient at the centre." – Tasmania consultation participant*

*"There is a recognition issue in terms of what qualifications a health worker has. Anyone can check Ahpra website to see qualifications, but [people with] low health literacy won't check. Most consumers don't care about specific qualifications, they just want care." – Brisbane consultation participant*

#### **Issue 2: Poor utilisation of workforce skills and ineffective workforce planning**

The inability to readily identify the skills and capabilities of primary care health professionals impedes effective utilisation of workforce skill and impacts health workforce planning. Underutilisation of health professional capability and skills impacts the care available to meet community need and contributes to poor professional satisfaction and workforce retention.

### Insights from consultation

*“There is [an] assumption there is choice for the market – in rural areas you don’t have much choice. You won’t care if it’s a physio, OT or chiro providing care, you just want to receive care.” – Melbourne consultation participant*

*“When I think about the people I know and from where I live, the idea of having access to a multidisciplinary idea is a luxury. I think there are other priorities around access to basic healthcare at the moment... The things you’re talking about, that’s great for people in the major cities, but there are people who are struggling for basic access. Scope of practice for where people don’t even have GPs, where nurses, practitioners, paramedics etc. can plug some of those gaps is a priority.” – Consumer consultation participant*

### Option for reform

Development of a framework and matrix that identifies the specific skills and capabilities of health professionals at entry to practice that informs local authorisation processes, the composition of the care team and workforce planning consistent with community need. **This reform option is assumed to be foundational for all other reform options.**

#### 1.1. Identify nationally accepted descriptions of scope of practice using existing systems

Identify professions that have defined their entry to practice scope at a national level and make visible to other professions to support an improved understanding. Professions yet to define professional scope should be facilitated to achieve this aim. The contribution of the paraprofessional workforce should be acknowledged, and their scope of activities understood and recognised.

#### 1.2. Develop a combined skills and capability framework, highlighting areas of shared scope and common capability

Based on recognised scopes of practice, develop a broad view of the skills and capabilities of the primary care team, including the contribution of individual health professions and the paraprofessional workforce. Identify common capabilities that fall within the scope of multiple professions to contribute to efficient skill utilisation. **Insights from consultation**

*“From an employer perspective – the prescriptive nature of contracts is a key barrier in achieving full scope of practice. The current nature of them almost enforces siloing. In reality, we could employ a multiskilled workforce but instead sometimes have to employ specific nurse practitioners (i.e., mental health) due to the prescriptive nature of contracts resulting from how professions are defined under SoP legislation. The change moves so slowly for regulatory and legislative changes to occur.” - Tasmania consultation participant*

#### 1.3. Align jurisdictional authorising processes with national scope descriptions

Streamline national, jurisdictional, and local skill recognition and associated authorising processes based on the skills and capability framework. (Refer also [Option 3: Early career and ongoing professional development includes multi-professional learning and practice](#)).

Promote the skills and capability framework and use the matrix to inform workforce planning to meet community need. Publish the framework to facilitate a greater collective understanding of health professional skills, including for consumers. Use the skills and capability framework to inform workforce planning in response to changing and future community need.

Use the skills and capability framework and matrix to shape the primary care team consistent with community need. An improved recognition of the skills and capabilities of health professionals will inform the best use of those available to contribute to primary care.

## **Implementation**

The following steps will be required to develop and implement a skills and capability framework for primary care health professionals:

### **Identify and collate descriptions of entry-to-practice scope:**

- Use Ministerial Council [as outlined by the National Law] i.e., Health Ministers Meeting (HMM) powers of policy direction to require National Boards to collate and publicise national descriptions of health professional skills and capabilities relevant to primary care.
- Where national professional capabilities are currently available, for example those that have been developed by regulated professions, national Boards should review these for relevance to primary care and highlight their application to this setting.
- Commence a body of work to identify, collate and assess the skills and capabilities of primary care health professionals not registered under the NRAS. These may be sourced from relevant organisations, including Tertiary Education Quality and Standards Agency (TEQSA), the National Alliance of Self-Regulating Health Professions (NASRHP). Skill and capabilities descriptions may be included in professional competency and/or capability descriptions, graduate outcome statements, program accreditation requirements.
- Combine identified skills and capabilities to form a broad view of the primary care workforce i.e., a National Skills and Capability framework and matrix. It is noted that substantial work has been undertaken to identify common skills and capabilities, including those required for rural and remote practice. The Rural and Remote Generalist Allied Health Project, completed in 2013<sup>27</sup>, led to the development of the Allied Health Rural Generalist Education Framework<sup>28</sup> which identifies common capabilities and profession specific skills.

**Promote the skills and capability framework.** Publicise the framework to contribute to a strengthened understanding of health professional role and scope of practice. Implement specific consumer awareness measures aimed at improving understanding of health

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<sup>27</sup> Greater Northern Australia Regional Training Network. Project Report: Rural and Remote Generalist - Allied Health Project. 2013. Accessed from: [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0025/656035/GNARTN-project-report.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0025/656035/GNARTN-project-report.pdf)

<sup>28</sup> Queensland Health. Allied Health Rural Generalist Education Framework (version 4.0). Accessed from: [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0032/695390/AHRG-Education-Framework.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0032/695390/AHRG-Education-Framework.pdf)

professional role and skill. Align with NRAS accreditation requirements for relevant professional entry courses.

**Jurisdictions, employer and health professionals utilise the skills and capability framework** to inform their understanding of health professional skill, and align with required local authorisations, including credentialling.

**Jurisdictions, employer and health professionals utilise the skills and capability framework** to inform the best use of available health professionals to respond to community need.

**Workforce planning** is informed by the skills and capability framework resulting in an improved ability to respond to, and plans to meet, community need.

### ***Intended Outcomes***

This reform option is intended to underpin and support other reform options detailed within this Issues Paper. Improved recognition and understanding of health professional scope will optimise:

**The function of the primary care team.** Effective use of the skills and capabilities of the whole primary care team will facilitate an efficient response to community need. It is anticipated that this may hold particular relevance to regional and remote areas where fewer team members may be available. An improved understanding of professional skills and capabilities, particularly between professions, will optimise collaborative care and improve care outcomes, as described in [Option 2: Develop primary health care capability](#).

**Primary care team flexibility and responsiveness.** Recognising the skills and capabilities of all contributors to primary care, including those of individual health professionals and those shared between health professionals, will contribute to an enhanced ability to respond to changes that impact health service delivery. Greater innovation in service delivery may be achieved through a clearer understanding and more complete utilisation of health professional scope.

**Improved workforce planning based on community need.** Planning informed by an improved recognition of available primary care skills, including those shared by multiple professions, will contribute to an improved response to community need.

A by-product of this policy initiative will likely be **improved professional satisfaction**, resulting from greater recognition and utilisation of health professional skills and capabilities

#### **Case description: use of the skills and capability framework**

A clearly defined skills and capability framework would provide a foundation from which primary care teams can be drawn together to meet community need. For example:

Regional and remote communities unable to attract specific health professionals could use the framework to identify roles that may be performed by equally qualified professionals from another discipline.

Jurisdictions use the framework to identify health professionals skilled to undertake roles in the event of a crisis or emergency e.g., supporting communities during national disasters.

## Stakeholder Impacts

### Primary care team

- Improved collaboration resulting from enhanced skill recognition and interprofessional trust.
- Improved team function, resulting from enhanced skill utilisation.
- Improved responsiveness and flexibility resulting from recognition of skills and common capabilities.
- Improved ability to consistently fund health professionals according to recognised and shared skills and common capabilities (refer [Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice](#)).

### Health service providers

- In addition to the above, health services will benefit from more streamlined role authorisation and credentialing processes founded in nationally defined skills and capabilities.
- A better-informed approach to workforce planning to meet community need.
- Innovation. A national skills and capability framework will enable health services to build and authorise local roles consistent with recognised skillsets. This may contribute to innovative service provision.

### Health professionals

- Improved team collaboration. National recognition of early career scope of practice will provide all health professionals with an improved understanding of the role of colleagues, including where their scopes overlap. It is envisaged this will contribute to greater trust between primary care team members, improved team collaboration and professional satisfaction.

### Health consumers

- Greater understanding of health professional role. Promoting the skills of health professionals will enable consumers to better understand the role of primary care team members.
- Improved access to health professionals able to contribute their skills to the local community.
- Optimised health outcomes. Improved team collaboration will contribute to optimised health outcomes for consumers.

## Challenges/Risks

**Skill definition.** Where entry-to practice skills and capabilities are not defined at a national level, significant development work will be required for their inclusion in the framework.

**Overlapping scopes of practice.** Where multiple professions share roles within their scope of practice, concern over professional boundaries may be raised.

**Culture and leadership.** Acknowledgement of professional skills, including common skill areas, in support of primary care improvements, will be facilitated by a strong culture of collaboration. National leadership of professional organisations and professional Boards will facilitate development of the skills and capability framework. Local leadership that supports the recognition of skill to inform service delivery planning, including new models of care, will contribute to improved primary care responsiveness.

### ***Measuring success***

Success will be characterised by:

- **Improved consumer awareness of health professional skills** leading to informed health care decisions and choice of health professional.
- **A responsive, flexible and innovative primary care team** that recognises its skills base and utilises it effectively to support optimal primary care in response to community need.
- **Improved health outcomes, including consumer experience**, resulting from more accessible and efficient primary care services provided closer to home.
- **Primary care team members have an improved understanding of the role of colleagues**, recognise shared capabilities and skills and trust other team members to contribute their skill to team outcomes.
- **Workforce planning** is informed by the skills and capabilities of the primary care team and able to meet community need.
- **Improved professional satisfaction and workforce retention** resulting from more comprehensive recognition and utilisation of professional skills and capabilities.

## Option 2: Develop primary health care capability

### Summary

Stakeholders identified the need for health professionals to develop the skills specifically required for primary care. Consultation revealed strong support for collaborative primary care teams, characterised by trust between team members and mutual recognition of skills, knowledge and capabilities. The development of professionals equipped to practise in primary care is supported by learning opportunities that specifically contribute to the development of primary care relevant skills, including collaborative skills, as a foundation for effective collaborative practice.

The Review acknowledges that some initiatives, particularly those offered by regional and remote education providers, including rural clinical schools, include enhanced training and recruitment opportunities.

### Issue 1: Poor visibility of primary care in the entry-level curriculum

Many health professional programs fail to explicitly include primary care learning in the curriculum. Experiential learning opportunities are commonly provided in the acute care settings, which may not provide optimal preparation for primary care practice.

#### Insights from consultation

Stakeholders identified challenges in preparing a primary care workforce unless this healthcare setting is explicitly visible in health professional entry-level programs.

*“Primary health care is where we are talking about an interdisciplinary model of care. This is missing in the undergrad curriculum.... Bachelor of Nursing courses include the topic of primary health care. Sometimes this topic is touched on in a rudimentary way but it is not fully embedded. Undergrad medicine courses also require more components on primary health care.” - Melbourne consultation participant*

### Issue 2: Insufficient support for Supervised Practical Training (SPT)

SPT forms a core component of many health professional programs, providing valuable context-specific skills that are not available in the classroom. It may take the form of internships, clinical placements or early practice post qualification. However, challenges hinder the completion of practical training, including poor availability of primary care opportunities and inconsistent supervision.

### Issue 3: Interprofessional education (IPE) requires strengthening

Education providers who offer programs of study for health professions regulated under the National Registration and Accreditation Scheme (NRAS) are required to demonstrate the inclusion of IPE in the curriculum, according to accreditation standards. These standards, however, differ between professions, and accreditation processes, which are applied at the individual profession level, may not be consistent between professions.



*“... the importance of ensuring the delivery of training and design of training. People who experience health inequities, real importance of the immersion, but how people live, is an important part of education and ... it needs to be done interprofessionally.” - Perth consultation participant*

## Options for reform

A safe, effective and responsive primary care workforce requires skilled and collaborative health professionals who deliver care focused on addressing consumer and community need.

### 2.1 Improve the visibility of primary care in the entry-level curriculum

The development of health professional equipped to practise effectively in primary care requires the inclusion of learning specifically focused on the primary care context, including experiential learning opportunities.

### 2.2 Support supervised practical training (SPT)

SPT experiences, completed in primary care, are essential to support the development of health professionals with relevant skills.

Learning opportunities require supervision provided by trained health professionals with appropriate primary care and supervisory skills, who are not required to contribute to regular service delivery during training periods. Consideration should be given to flexible models of interprofessional supervision, especially where profession-specific supervision is unavailable.

### 2.3 Strengthen interprofessional education (IPE)

Interprofessional education has been shown to improve health outcomes<sup>29</sup>. The development of a competencies framework for IPE would support national accreditation processes for regulated professions. Self-regulated professions and education providers contributing to the paraprofessional workforce may reflect the national competencies. The framework would support the inclusion of consumer input to the design and development of the curriculum, to strengthen the focus on patient-centred care.

A broader view of the primary care team, as suggested in [Option 1: National Skills and Capability Framework and Matrix](#) will contribute to greater interprofessional understanding and improved collaborative practice.

## Implementation

**Education providers** will be required to:

- Define primary care learning objectives (including those relevant to SPT) for the curriculum.
- Identify and facilitate opportunities for quality primary care learning experiences.

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<sup>29</sup> World Health Organization. Framework for Action on Interprofessional Education and Collaborative Practice. 2010. Accessed from: [https://iris.who.int/bitstream/handle/10665/70185/WHO\\_HRH\\_HPN\\_10.3\\_eng.pdf?sequence=1](https://iris.who.int/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1)

- Actively include consumer input into the design and development of curricula focused specifically on developing skills to support optimal patient-centred collaborative care.
- Establish a team of appropriately trained supervisors to support SPT.
- Lead curricular changes in support of improving the preparation of learners for practice in primary care, including the inclusion and/or enhancement of IPE content.

**Accreditation authorities** will be required to:

- Introduce and/or update accreditation standards to specifically reference primary care learning opportunities, IPE and opportunities to complete SPT focused on primary care where possible.
- Develop and introduce accreditation standards that require education providers to align curricula content with the IPE competencies framework. While it is recognised that IPE is currently reflected in many regulated profession accreditation standards, there are inconsistencies in how these standards are implemented and the processes employed by accreditation authorities to review this aspect of the curriculum. Alignment with an IPE competencies framework would therefore contribute to a consistent approach to the implementation of accreditation standards and provide a framework for self-regulated professions. Professional capabilities could also reference the IPE competencies framework.
- Provide leadership and promote the national IPE competencies framework.

**Ministerial Council policy direction:** Consider utilisation of HMM's powers of policy direction to require National Boards to work with accreditation authorities to undertake work to develop and implement accreditation standards consistent with this reform option. Refer also [Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach](#).

**Cross professional collaboration:** Development of a national IPE competencies framework will require contributions from a range of stakeholders, including regulated and self-regulated professions and the paraprofessional workforce. Incorporate this into the proposed [Option 1: National Skills and Capability Framework and Matrix](#).

## ***Intended Outcomes***

1. **The inclusion of primary care learning opportunities in the entry-level curriculum** will provide context relevant skills and knowledge to support primary care practice.
2. **Supported SPT** will enable learners to complete required practical training supervised by experienced and appropriately trained health professionals who are readily available to engage with the learner. Patient interactions experienced during SPT facilitate learner understanding of primary care roles and the patient perspective and may also contribute to interprofessional learning.
3. **Strengthened IPE.** Australian competencies for IPE would guide education providers in curricular design, development, and delivery, leading to improved graduate understanding of, and skills relevant to, collaborative practice. This reform option links

with existing work undertaken by the Health Professions Accreditation Collaborative (HPAC) Forum<sup>30</sup> and the Ahpra Accreditation Committee<sup>31</sup>.

## **Stakeholder Impacts**

### **Early career health professionals**

- Improved skills specifically relevant to primary care.
- Streamlined transition to practice requiring reduced supervision and/or mentoring during the early post-qualification period (noting that this will complement mechanisms proposed in reform options [Option 2: Develop primary health care capability](#) and [Option 3: Early career and ongoing professional development includes multi-professional learning and practice](#)).
- Ability to attract early career health professionals to primary care (including in regional and remote areas) due to the acquisition of skills specifically useful to primary care.
- Improved student completion of required experiential learning due to an improved number of learning opportunities.
- Enhanced skills in collaborative practice resulting in improved primary care cohesion.

### **Education providers**

- Provision of SPT in primary care settings may require the development of community links and the establishment of additional learning content.
- Clarity regarding the intended outcomes of IPE provided by a competencies framework, will guide the design, development and delivery of health professional education programs and improve consistency across professions.

### **Accreditation Authorities**

- The development and/or review of accreditation standards to ensure clear expectations of (a) the visibility of primary care, (b) the involvement of health consumers in program design and development particularly in relation to developing the skills required for collaborative practice, and (c) IPE learning opportunities, aligned with an IPE competencies framework, in the entry-level curriculum, would contribute to greater consistency between professions and improved educational outcomes.
- Contribute to the development of a national skills and capability framework (refer [Option 1: National Skills and Capability Framework and Matrix](#)) by clearly defining the accreditation standards for entry-level programs consistent with this policy reform option.

### **Health Service Providers**

- Early career health professionals equipped with the skills to move into primary care roles with limited support.

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<sup>30</sup> Interprofessional Education: Report on the findings of a survey of HPAC Forum members (2020) Accessed from: <http://hpacf.org.au/wp-content/uploads/2022/05/Final-report-HPAC-IPE-survey-1.pdf>

<sup>31</sup> Ahpra Accreditation Committee Interprofessional Collaborative Practice Statement of Intent. Accessed from: <https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx>

- Improved understanding and respect for the capabilities of health professional colleagues resulting from IPE initiatives.
- Enhanced collaborative skills developed during health professional programs.

### **Health Consumers**

- Improved primary care team collaboration resulting in better co-ordinated care.
- Better care provided by health professionals specifically equipped to undertake their role.
- Specific input to the development of health professional education programs.

## **Challenges/Risks**

**Inability or unwillingness to include primary care in entry-level programs.** SPT undertaken in the primary care setting may be viewed as unnecessary and/or irrelevant by some education providers, accreditation authorities or primary care workplaces leading to difficulties in incorporating in education programs.

**Inability to identify an adequate number of SPT opportunities.** Accessible learning opportunities are necessary to support primary care experiences.

**Inability to attract trained supervisors.** Dedicated trained supervisory positions are required to support quality SPT. These may also be referred to as clinical educators or preceptors. Service delivery will be impacted if supervisors are expected to complete regular duties in addition to supervising learners. Interprofessional supervision, where appropriate, may provide a mitigating strategy.

**Inconsistent/poor adoption of IPE competencies.** Failure of professions, accrediting authorities and/or community settings that contribute to education, to adopt the national IPE competencies, will result in inconsistent outcomes. Leadership in professional and accrediting organisations, educational institutions (at the faculty and school levels), and workplaces (at the management and health professional levels) will be required to support adoption of IPE competencies.

**Workplace culture not supportive of collaboration.** Where graduates have completed IPE education and enter a workforce characterised by poor collaboration, the ability to practise collaboratively may be impeded.

**Regulatory amendments** to support interprofessional supervision may be required for some professions. For example, where a National Board stipulates that workplace-based learning experiences in a pre-entry qualification program be supervised by a particular profession, amendments will be required to enable another health profession to undertake this role. This change could subsequently be reflected in accreditation standards.

## **Measuring success**

Success will be characterised by:

- **The inclusion of primary care learning experiences in entry-level health professional curricula** evidenced by accreditation findings that indicate the inclusion of primary care learning experiences, SPT and consumer-specific perspectives.
- **Health professional graduates** are prepared to undertake primary care roles without requiring additional post-entry qualification training.

- **Students** have access to SPT opportunities supervised by experienced and trained supervisors and are enabled to complete their training.
- **Learner supervision** is provided without negatively impacting service delivery.
- **Graduates** are prepared for collaborative practice.
- **Health consumers** are enabled to provide input to the design and development of educational curricula.

**Case description: Improved preparation for primary practice in an entry-level program**

Should the reform options be adopted, health professional students completing an entry-level program could expect primary care to be visible in the program, including both theoretical and practical elements, and to develop the skills to practise in the primary care setting.

The health professional student would be enabled to:

- *Learn about* primary care early and throughout the program.
- *Experience* primary care, supervised by an experienced and trained supervisor.
- *Learn with, from and about* other health professions consistently throughout the program.
- *Experience interprofessional collaboration* during supervised practical training. This may include being supervised by a member of a different profession.
- *Complete required supervised practical training* (regardless of setting but including primary care) supported by experienced and trained supervisors, which include those from another profession.

## Option 3: Early career and ongoing professional development includes multi-professional learning and practice

### Summary

Several issues impact the ability of primary care health professionals to develop, maintain and enhance skills, including the ability to access opportunities to learn in this setting. Inconsistencies exist in post-entry qualification education and training, leading to poor role recognition and confusion about health professional scope. Literature describes examples of post-entry qualifications developed according to a shared standards framework operating across professions and referred to using common language <sup>32</sup>. Achieving this type of consistency requires role clarity, skill recognition and education, training and supervision specifically designed to support role development.

#### **Issue 1: Poor support for early career health professionals to develop primary care skills**

The transition from student to professional requires guidance and support to develop the skills necessary for practice in primary care. Where these skills have not been a focus of pre-entry education and training, there is a need for early career health professionals to develop and consolidate, under guidance, the specific skills required for primary care.

#### **Issue 2: Challenges completing post-entry qualification education and training**

Many primary care health professionals experience barriers to completing the education and training required to maintain and/or enhance their skills and knowledge, including mandatory continuing professional development (CPD) requirements. Health professionals may experience challenges in accessing, funding and/or completing education and training. Access may be restricted or prevented by issues that affect physical or virtual accessibility; support may be required to access education and training and/or to engage appropriate personnel to provide practice cover; time to complete education and training may be excessive. These issues are particularly relevant for health professionals that practise alone, where the time required to complete education and training may result in lost income during that period.

#### **Issue 3: Inconsistencies in post-entry qualification education and training**

Post-entry qualification, a range of education and training options are available to build professional capability. However, inconsistencies can be identified in the standards that underpin education and training, the professional title (where relevant) available after completion of a program, the impact of additional qualifications on scope and how this is practically recognised by peers and consumers.

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<sup>32</sup> Kuczawski, M., Ablard, S., Sampson, F., Croft, S., Sutton-Klein, J., & Mason, S. (2024). Exploring advanced clinical practitioner perspectives on training, role identity and competence: a qualitative study. *BMC Nurs*, 23(1), 185. <https://doi.org/10.1186/s12912-024-01843-x>

### Insights from consultation

Poor recognition of health professional skills was one of the most common comments received by consumers and health professionals alike during consultation. This comment highlights a lack of understanding identified as existing between education providers.

*“There is a lack of understanding of what the actual scope of practice is for a HP, there is racism floating around in there but also opportunity for a piece of work to be undertaken and led around genuinely what are people’s SOP. Assumption that education and VET understand each other – they do not. Real disrespect on many levels towards that. There are big system underlying issues – but other policy barriers that need to be considered in the inter-section between VET and higher education.” - First Nations consultation participant*

### Issue 4: Infrequent opportunities to participate in multi-professional learning (MPL)

Consultation identified strong support for MPL, particularly where specifically relevant to the practice context. For example, primary care professionals that share common practice areas benefit from learning together, focused on their shared clinical practice e.g., midwives and general practice obstetricians working together in regional areas. It was, however, noted that such opportunities are infrequently available.

*“Multidisciplinary teams need creative/innovative and sometimes specialised training depending on area of collaboration. Multidisciplinary collaboration requires focused training to support it, including to recognise and respect overlapping scope.” – Consumer consultation participant*

### Options for reform

Mechanisms proposed to improve the issues highlighted include funding mechanisms and system processes.

#### 3.1 Support early career health professional development

Support for professionals to negotiate the transition from education to practice may include supervision and/or mentorship programs that build on the skills acquired during entry-level programs and develop primary care specific skills and capabilities. Supervision may be provided for unfamiliar tasks and mentorship to consolidate and enhance established skills. Programs that provide this type of early career support are available for some professions.

Greater access to early career support would require:

- **An adequate number of skilled primary care supervisors and mentors** to provide health professional support without impacting healthcare delivery.
- **Processes** that direct structured supervision and mentorship in primary care, including the identification of tasks for which specific preparation is required and who is appropriately trained to provide relevant guidance.



### **3.2 Facilitate health professionals to complete post-qualification education and training**

- Support primary care professionals to access relevant education and training.
- Develop an accessible pool of trained health professional locums available to facilitate attendance at in-person education and training particularly for regional and remote health professionals.
- Systems that enable protected time to complete required education and training. For professionals that practise alone, this will require access to locum support.

### **3.3 Facilitate national consistency in post-qualification education and training**

**Processes** that ensure education and training programs that develop similar graduate capabilities/outcomes are based on agreed professional standards and/or competencies, including those relevant to multiple professions. Where relevant, programs should employ consistent titles for common capabilities and, where appropriate, qualification. Refer also reform options [Option 1: National Skills and Capability Framework and Matrix](#) and [Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach](#).

### **3.4 Facilitate MPL learning to support health professional development and the primary care team**

Support the development of education and training packages specifically designed for MPL in primary care and provided using a range of teaching methods e.g., face-to-face, online, simulated.

**Processes** that direct and incentivise health professionals to participate in learning with multiple professional colleagues e.g., the requirement for a component of mandatory CPD to be undertaken with professionals from other disciplines and/or members of the paraprofessional workforce.

**Provide support** to facilitate health professionals to attend MPL opportunities.

*“Silver Chain Hospice is a really good example. Community-based team that is based in Perth, and when they have educational events, the whole team will go. It is a really good model for the whole team to get education and training.” – Perth consultation participant*

## **Implementation**

### **Define the process for supervision/mentorship**

- Professional organisations, in consultation with health professionals, employers and education providers, identify the primary care tasks/practice areas that require supervision and/or mentorship at a national level.
- Education providers determine, and agree at a national level, the skills required of primary care supervisors/mentors and how these will be achieved.
- Professional organisations, in consultation with employers and education providers, establish the duration of early career support for primary care and the required outcomes.

### **Develop and resource a pool of trained locums to support health professionals to complete education and training**



- Identify mechanisms that utilise, co-ordinate and enhance existing locum resources for a broader range of primary care professions.

#### **Establish processes that support consistency in education and training:**

- Where multiple professions share primary care capabilities, professional organisations, education providers and regulators should determine the appropriate professional standards/competencies that underpin the education and training to develop capabilities.
- Education and training programs that lead to common primary care qualifications should meet common accreditation expectations and be referred to with consistent qualification titles. Professional organisations, national Boards, accreditation authorities and education providers will be required to reach agreement on this practical aspect of consistency.

**Health Ministers' Meeting (HMM) direction:** Consider utilisation of Ministerial powers of policy direction to instruct National Boards to work toward achieving consistencies in post-entry qualification education and training, including through accreditation processes (where applicable) and CPD requirements. For example, CPD requirements may stipulate a period of multiprofessional learning, where relevant.

### ***Intended Outcomes***

**Early career health professionals are supported to establish safe and effective foundational skills and capabilities in primary care.** Support, in the form of structured supervision and/or mentoring, contributes to a seamless transition from student to professional. This dovetails with [Option 2: Develop primary health care capability](#) which supports the early development of primary care skills during entry level programs.

**Health professionals are enabled to access, attend and complete education and training** resulting in consistent maintenance and improvement of primary care skills. A potential additional outcome may be improved professional satisfaction.

**Education and training that develops common capabilities (either pre- or post-entry qualification) is recognised nationally** and developed according to consistent professional standards across professions resulting in improved health professional skill recognition and utilisation.

This reform option would also contribute to greater interprofessional trust in capability. Additional outcomes may be an improved professional satisfaction and enhanced consumer understanding of health professional skills.

**Primary care teams are supported to attend MPL** increasing team capability, trust and cohesiveness. This reform option builds on the IPE experiences provided in pre-entry curriculum into the workplace (refer [Option 2: Develop primary health care capability](#)).

### ***Stakeholder Impacts***

#### **Health professionals**

- Supported to develop primary care skills early in career and subsequently to maintain and enhance required skills.
- Improved understanding of common capabilities due to national consistency in programs and in qualification titles.

- Supported to learn with colleagues from other professions/para professions, resulting in an improved understanding and recognition of colleague skills and trust in their capabilities

### **Primary care teams**

- Improved team cohesiveness based on greater skill and capability recognition.
- Improved team-based skills developed through learning together.

### **Health Consumers**

- Improved care provided by health professionals equipped with current primary care specific skills.
- Health care reliability resulting from recognition of common capabilities and team flexibility in providing care.
- Improved ability to recognise health professional skills, resulting from common titles for common capabilities and qualifications.
- Experience of care provided by a cohesive primary care team equipped with skills learnt together and appropriately maintained.

## **Challenges/Risks**

**Inability to source and train the required number of supervisors.** For professions that do not currently offer early career supervision/mentorship, a commitment to develop the supervisor/mentor workforce will be required. This may require a shift in culture toward nurturing early career professional skills and appropriate leadership to commit to this goal.

**Inability to develop a team of appropriately trained locums to support health professionals** attend education and training. Leadership will be required to facilitate professionals that practise alone to identify and access locum support to complete education and training.

**Inability to achieve agreement on nationally consistent education programs for common capabilities.** Where national professional standards/competencies are unavailable, achieving consistency in education programs will be inhibited, potentially resulting in inconsistent capability development. Recognition of the importance of consistency will be facilitated by leadership.

**Lack of relevant education programs available for MPL.** Inability to access relevant education and training, available across a range of platforms, and designed for multiple professions.

**Lack of commitment to MPL/ poor adoption of MPL.** Professionals that practise alone may fail to participate in MPL, especially where training is not specifically relevant to their practice. Supported involvement, combined with a cultural expectation that primary care teams learn together, will be required.

## Measuring success

Success will be characterised by:

- **Support is available** for early career health professionals to establish primary care skills with supervision and/or mentorship. This will have a positive effect on workforce attractiveness and staff retention.
- **Health professionals are enabled** to access and complete education and training and expected to include multiprofessional learning as part of their CPD.
- **Primary care professions recognise, understand and trust the capabilities of their colleagues** as a result of consistent education and training, and qualification titles, between professions.
- **Improved primary care team cohesiveness** resulting from opportunities to learn together and the ability to recognise and trust common skills and capabilities.
- **Health Consumers** are able to access primary care services provided by appropriately trained health professionals with recognised skills and capabilities.

### Questions for further consultation: Workforce design, development and planning

- Do you believe the combined options for reform will address the main policy issues relating to workforce design, development and planning you have observed in primary health care scope of practice?
- To what extent do you believe these policy options will help to drive the policy intent of the Review in supporting multidisciplinary care teams to work together to full scope of practice?
- Are there implementation options which have not been considered which could progress the policy intent of these options for reform?
- Based on your experience, what features should a skills and capability framework have to ensure it is useful in practice?
- How should the framework be implemented to ensure it is well-utilised?
- What do you see as the areas where the framework will have the greatest impact on scope of practice?
- How do you see the recognition of common capabilities and skills in the framework contributing to the delivery of primary care?
- Who do you see providing the necessary leadership to ensure the framework achieves the goal of contributing to health professional scope of practice in primary care?

## 4b. Legislation and regulation

Evidence gathered to date have contributed to three proposed reform options related to legislation and regulation:

- Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach
- Option 5: Independent, evidence-based assessment of innovation and change in health workforce models
- Option 6: Harmonised Drugs and Poisons regulation to support a dynamic health system

### Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach

#### Summary

While broadly Australian legislative and regulatory mechanisms which apply a 'named profession' or 'protected title' approach to regulating scope, have generally served Australia well in a protection of public safety sense, there have been downsides for scope of practice. This approach is highly specific in naming professions who are authorised to perform particular activities, and/or the settings or employers under which they are authorised to perform those activities (see [3b. Alignment with legislation and regulation review](#)). A potential complementary approach, focusing on specific activities which are then mapped to health professionals who are already competent (or could become competent) to perform that activity, is referred to as an 'activity based' or 'risk based' approach. This approach exists in practice in some international jurisdictions, such as Canada.

*"If I did a search of the national legislation, could I find multidisciplinary teams or interdisciplinary in that? If there was to be something included in the legislation to require all the boards to invest seriously in multidisciplinary team care, it would force them to work with each other and begin to understand what that needs to look like." - First Nations consultation participant*

#### Issue 1: Highly restrictive regulation which arbitrarily limits scope of practice

The Health Practitioner Regulation National Law Act 2009 (National Law), which focuses on named professions, is broadly enabling of full scope of practice. However, the overall regulatory environment, consisting of other Commonwealth legislation and funding rules supported by a patchwork of state and territory legislation, erodes health professionals' ability to work to full scope of practice in the following ways:

1. By specifying named professions, or named settings or employers;
2. Significant prescriptiveness about the conditions in which MBS funding is attached to which activities delivered by whom and under which circumstances, primarily through the Health Insurance Act.

The Health Insurance Act is particularly prescriptive about the requirement for a medical professional to instigate, oversee and approve activities performed by non-medical health professionals in a multidisciplinary care team setting, resulting in an overall medico-centric model of primary health care and restricted scope for most other professions. It is noted that restricting actual scope of practice is outside the intent of the Health Insurance Act, which governs how health professionals are paid for the tasks they perform; but has the indirect effect in practice of limiting scope of practice among those professions who are not named/funded.

#### **Insights from legislative and regulatory review**

For example, a review of the Health Insurance Act and associated legislative instruments found that there is no MBS-funded pathway for Registered Nurses to conduct attendances for patients (including for the purposes of assessing mental health care needs and instigating a mental health care plan). This would impact their scope of practice in delivering mental health-related care.

Further complexity surrounds medical indemnity coverage, which was described in consultation as not consistently covering full scope of practice despite being designed to reflect this (for example, nurses not being indemnified to perform skin checks where this is required in rural areas). In cases where care is delegated from one professional to another (acting 'for and on behalf of' that professional) there is additional complexity in the interpretation of indemnity, although it is noted that all health professionals are required to maintain their own indemnity coverage.

#### **Issue 2: Shorthand references to National Law exclude particular professions**

In addition to this, there are examples of Commonwealth, state and territory legislation making reference to the National Law in order to authorise who can perform an activity. This acts as a significant barrier to health professions who are not regulated under NRAS from working to their full scope, and in particular excludes self-regulated professions. This is highly interrelated with proposed harmonisation of Drugs and Poisons legislation, as seen in the example below.

#### **Insights from legislative and regulatory review**

A regulatory review of all state and territories' Drugs and Poisons legislation found that the definition of 'health practitioner' acts as a shorthand reference to NRAS-regulated professions under the National Law, precluding self-regulated professions from being authorised to prescribe, supply/dispense or administer medicines, even where these activities may fall under their training, competency and scope.

#### **Insights from consultation**

A Victorian example was raised where pharmacists working in regional Urgent Care Centres are prevented from supplying medicines unless there is a medical practitioner on the premises, despite the fact that most weekend and after-hours urgent care is provided by nurses in this setting. Consumers are therefore prevented from being supplied medicines when medical practitioners are not present.

### Issue 3: Legislative and regulatory environment not keeping pace with emerging primary health care practice

The restrictive nature of the regulatory landscape, as described above, means that the system remains relatively static in adapting to better practice and emerging service delivery and workforce models. Numerous examples were raised during consultation of emerging practice models or treatments which are not incorporated into Australian legislation in a timely manner, some of which are more readily introduced into practice in overseas jurisdictions.

#### How do international jurisdictions regulate risk-based scope?

**New Zealand:** Regulation of health professionals is legislated under the Health Practitioners Competence Assurance Act (2003), which established a single regulatory framework for health professions. Prior to this, the Ministry of Health administered 11 occupational statutes covering 18 health professions. The Act establishes a single regulatory framework – the overall administration, the primary responsibility, accountability, and overall functioning of regulation rests with the respective professional authorities.

**Canada:** Regulation of health professionals occurs through each of the provinces and there is no National Scheme. Whilst many provinces have moved towards an ‘umbrella framework’ to complement title protection, Nova Scotia has additionally adopted consolidated legislation for 21 self-regulated health care professions and will make self-regulating professionals members of a ‘Network’ to facilitate ‘opt-in’ collaboration.

**United Kingdom:** Regulation of health professionals by ten separate, national statutory organisations which share a common set of core activities but differ in how legislation and standards have been developed. Scope is regulated through these regulatory bodies including enacting changes to scope.

### Options for reform

Three solutions are proposed to build on the current focus on title protection by enabling a complementary risk-based approach to regulation. These actions should align broadly with the proposed shift towards a skills-based framework (refer [Option 1: National Skills and Capability Framework and Matrix](#)).

#### 4.1. Risk-based approach to regulating scope of practice around certain higher-risk activities

To complement the current focus on title protection, a risk-based approach should be pursued to regulate certain high-risk activities which fall (or potentially fall) under the scopes of multiple professions. Under the National Law, the Health Ministers Meeting (HMM) – acting as the “Ministerial Council”, has the power to issue policy directions to Ahpra and National Boards, and in so doing may instigate reform action in a particular direction, in relation to a number of matters including practice standards.

In the first instance, the HMM could direct National Boards to identify certain high-risk or shared activities for which to implement a standard risk-based approach to regulating that scope across professions. For example, vaccination, prescribing medicines, management of acute mental health episodes.

The policy intent is to complement, not replace the existing protected titles approach, by making professional standards / scope more explicit about specific activities and functions where:

- There is significant overlap across the scope of professions where such activities can be performed within scope; or
- The activity is novel or poses a high risk of patient harm.

This could be achieved by one of two key approaches:

- A. **National Boards maintain separate practice standards or guidelines**, each amending to reflect the agreed principles and scope of practice (aligning more closely to status quo approach to defining scope on profession-by profession basis).
- B. **Moving towards a risk-based or activity-based approach** in which a defined list of limited high-risk and shared-scope activities is developed to sit over the top of separate professional practice standards or guidelines. These activities are then mapped to professions according to whether they fall under each profession's scope of practice (larger scale reform, but more closely aligned to a genuinely risk-based regulatory reform direction).

Each of the above would enable scope to be more directly regulated under a risk-based approach rather than indirectly under the protection of individual profession-specific practice standards, in line with broader reform direction.

This relates to the responsibilities of a new *independent body* proposed to be tasked with identifying and implementing emerging best practice evidence into primary health care workforce models on an ongoing basis.

#### 4.2. Consider amendment to National Law in relation to Accreditation Authorities

Commonwealth and state and territory health ministers could consider an amendment to the National Law to expand the existing power of the Health Ministers' Meeting (HMM) to give policy directions to Ahpra and National Boards to include a power to give policy directions to Accreditation Authorities.

At present, the HMM may issue a policy direction to Ahpra and National Boards about the relevant National Board's expectations with respect to accreditation and training within the relevant profession, but this power does not currently correspond to issuing policy directions to Accreditation Authorities directly. This reduces the extent to which scope of practice reform can be implemented into accreditation processes (see also [Option 2: Develop primary health care capability](#)).<sup>33</sup>

#### 4.3. Identify legislation impacting scope and work towards harmonisation

In parallel with the above, and in line with the policy intent set by the Health Ministers Meeting, Commonwealth, state and territory governments work to identify legislation which limits scope and pursue harmonisation to the extent possible. It is likely that issues identified

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<sup>33</sup> For example, Ministerial Policy Direction 2023-1: Medical college accreditation of training sites (1 September 2023). Accessed from: <https://www.ahpra.gov.au/About-Ahpra/Ministerial-Directives-and-Communiqués/Policy-directions.aspx>



in [Option 6: Harmonised Drugs and Poisons regulation to support a dynamic health system](#) will also occur in other subjects of legislation and regulation which either directly or indirectly impact on scope of practice – refer to longlist. Therefore, the approach to harmonisation would broadly follow the approach detailed under Option 6..

Although the National Law itself is not expected to be a priority for amendments (given its relative flexibility and enabling powers over scope), harmonisation in how legislation makes reference to the National Law (both directly and indirectly) to arbitrarily limit scope should be pursued as part of this work. This also includes considering the scope of self-regulated professions in relation to relevant legislation.

#### **4.4. Develop guidance to promote consistency and future-proof scope of practice legislation and regulation**

Over the longer term, a continuous improvement approach would help to strengthen and modernise primary health care practice and ensure it remains current with best practice innovations. On this basis, future drafters would be encouraged to use guidance material endorsed by the Health Ministers Meeting relating to their professional capabilities or equivalents. This guidance should particularly prioritise:

- Opportunities to apply a risk-based regulatory approach versus when to default to National Law protected title professions.
- Definition of ‘health practitioner’ and other key definitions throughout jurisdictions.

### **Implementation**

**Health Ministers Meeting initiates policy direction.** Using its powers under the National Law, the Health Ministers Meeting request National Boards and Ahpra to commence work to identify areas of scope overlapping across professions they regulate. [\(Short-term\)](#)

**Identification of high-risk activities or activities falling within an overlapping scope across professions.** National Boards and Ahpra agree principles and a shortlist of activities which will be subject of proposed risk-based reform. Agreement reached whether to implement reform via existing suite of professional capabilities or equivalent, or introduce overlay of risk-based standards for particular activities. [\(Medium-term\)](#)

**Implementation of scope of practice changes.** Based on the above, National Boards implement changes to the relevant professional capabilities or equivalent. [\(Medium-term\)](#)

**Identification and amendments to legislation that limits scope of practice.**

Commonwealth, state and territory governments work to identify legislation which limits scope within their jurisdictions (may include legislation which is not directly concerned with regulation of health professionals). [\(Medium-term\)](#)

**Harmonisation of legislation and regulation.** Based on the above, governments pursue harmonisation (including consistency in references to the National Law within other legislation) to the extent possible in line with intent of Health Ministers Meeting policy direction. [\(Long-term\)](#)

**Guidance provided to legislators and regulators.** Promotion of Health Ministers Meeting guidance to advise ongoing approaches to developing legislation and regulation with a risk-based focus. [\(Ongoing\)](#)



## Intended Outcomes

**Improved clarity around scope of practice.** Clear policy intent and consensus around scope of practice is communicated, agreed and pursued by decision-makers. Arbitrary barriers to health professionals working to full scope of practice are removed, and there is clear direction about which activities they are authorised to perform.

**Improved multidisciplinary care team functioning.** All members of the care team will have improved understanding of their roles and scopes of practice, including where these overlap (refer [Option 1: National Skills and Capability Framework and Matrix](#)).

**Modernised and future-proofed system.** The primary health system will become more adaptable to emerging practice and less fixed to current service delivery models, allowing best practice to be more readily implemented on an ongoing basis.

## Stakeholder Impacts

**Consumer:** The consumer would benefit from greater clarity about what services they can receive from which health professionals, and from the wider range of health professionals enabled to perform particular activities.

**Health professionals:** Increased professional satisfaction is likely to result from a greater degree of clarity, and overall system responsiveness to best practice evidence. Multidisciplinary care teams are enabled to work together to collective full scope, with improved interprofessional understanding and trust. This reform option would particularly enable a balanced view of risk in rural and remote regions, responding to relative lack of access to services and health professions.

**Government:** Positive impacts for decision-making on an ongoing basis in light of consensus-making process driven by the Health Ministers Meeting policy direction. Improved system responsiveness enables a health system which is able to keep pace with (and contribute to) international best practice.

## Challenges/Risks

**Assurance of competency.** Introduction of a risk-based approach may initially present less clarity in terms of level of competency. In the interests of patient safety, National Boards are tasked with carefully considering professional competencies in determining which professions can safely perform identified high-risk activities.

**Complexity of implementation.** There is a risk of policy misalignment between the objective of supporting full scope of practice and existing funding rules, which seek to control unsustainable expenditure. Furthermore, each of the implementation options detailed in this reform option will require significant engagement in order to reach consensus between all decision-makers.

**Reductionism.** The risk of clinical practice being reduced to a list of competencies was also raised during consultation. Options for reform which highlight the role of the multidisciplinary care team will be critical to implement in parallel to ensure siloed practice is not unduly reinforced, and that the non-consumer facing aspects of collaboration are adequately recognised (e.g., through block and blended funding). Professional capabilities that are broadly articulated and regularly reviewed are also important.

## *Measuring success*

**Increased harmonisation.** There is a greater degree of consistency in state and territory legislation (both current and future) which directly or indirectly impacts scope of practice.

**Decreased barriers to scope of practice.** Health professionals (both regulated under NRAS and self-regulated) experience fewer barriers to working to full scope of practice.

## Option 5: Independent, evidence-based assessment of innovation and change in health workforce models

### Summary

New research, local innovation and emerging technology has the potential to continually improve the way health care is delivered. However, health care professionals point to many examples of the negative impacts of a highly prescriptive and inflexible legislative and regulatory environment on the adoption of better practice workforce models.

NRAS has been pivotal in improving national consistency in regulatory policy and harmonised legislation. The Boards established under NRAS have an important role in defining the professional scope for each of the 16 individual regulated professions. However, there is currently limited evidence or focus on what is happening in practice and whether the current combined profession-specific scopes of practice of health professionals are meeting community need. This risks a siloed approach to considering scopes of practice, and the risk of professional interests being given preference over the public interest.

Progressing evidence-based, significant reforms to scope of practice, such as prescribing, has proven to be an unnecessarily complex process requiring decades of work across professions, regulators, Commonwealth, State and Territory governments and officials. Such progress has involved ad-hoc investigative processes, one-off reviews and complex intergovernmental mechanisms to settle the case for change and sensible reform. There is a case for the establishment of a robust, repeatable institutional mechanism to progress the business case for sensible workforce reforms in a more timely and ongoing manner.

### Option for reform

#### 5.1 Independent national body for assessing evidence underpinning proposed reforms to scope of practice

Establish an independent body responsible for providing advice to governments and regulators on how the scopes of practice for health professionals can continue to meet community need. This body would be responsible for considering how emerging evidence, including in relation to new technology, new roles and new workforce models, impact the combined scopes of practice (both overlapping and distinct) of health professionals.

This body would exist as an independent advisory committee, either as a newly formed autonomous national body or sitting under the remit of an existing national body (such as Ahpra). It would serve a continuous improvement and innovation adoption function similar to that of the Medical Services Advisory Committee (MSAC), Pharmaceutical Benefits Advisory Committee (PBAC), MBS Review Advisory Committee (MRAC) or the Health Technology and Genomics Collaboration (HTGC) in their respective areas. Its scope would include engagement with governments, Boards, professions and other regulators to enable evidence to be objectively assessed and ultimately translated into practice.

Consideration of the outputs of the independent body should form a mandatory precondition of actions taken by Ahpra, the National Boards and jurisdictions on significant scope of practice reforms, in the early stages of considering and implementing reform options.

### Insights from consultation

An example provided of a Remote Area Paramedic model being trialled in a remote area highlights several elements relating to legislative and regulatory scope of practice issues. Intended to complement existing Remote Area Nursing (RAN) models, the paramedic role holds specific expertise in emergency medicine highly relevant to the remote primary health context, and undertakes training alongside RANs.

## Implementation

**Define terms of reference.** The role and authorisations of the independent body should be established. As key part of this process, a decision must be reached in whether the body should be wholly independent, or sit within an existing institution such as Ahpra. **(Short-term)**

**Engage partner institutions.** Engagement should be conducted with all major institutions and decision-makers who will interface with the new body, to ensure its role and authorisations are understood. **(Medium-term)**

**Engage advisory members.** Members of the independent body should be engaged in parallel with the above. They should be independent and hold expertise in scope of practice, primary health research and economics. **(Medium-term)**

**Interface with Skills and Capability Framework and Matrix.** As a core part of its function, the independent body should interface with [Option 1: National Skills and Capability Framework and Matrix](#) to ensure best practice models of care or changes to scope of practice are reflected in skills mapping, and vice versa. **(Ongoing)**

## Intended Outcomes

**More evidence-based practice.** Best practice evidence relating to health workforce scope of practice is incorporated more readily into on-the-ground delivery, enabling health professionals to work more consistently to their full scope of practice.

**Greater legislative and regulatory responsiveness.** A more dynamic, continuous improvement approach responding to new evidence about scope of practice avoids inertia in amending legislation regulatory instruments, practice and education standards.

**Greater transparency and public trust.** The independent body would enable improved transparency as to how evidence-based decisions are made about scope of practice, and to what extent the public interest and professional interests were a consideration in these decisions. All stakeholders can therefore hold greater trust that primary health care decision-making is done in the primary interests of community need, flexibility, team-based practice and accountability.

## Stakeholder Impacts

**Government:** Decision-makers have continuous access to the most up-to-date evidence about what works in primary health care scope of practice.

**Health professionals:** The health workforce is able to adapt to internationally recognised best practice in what they are trained, competent and authorised to do.

**Health Consumers:** Better and more timely access to health services provided by health professionals working to their full scope, following internationally recognised best practice. Improved confidence and trust in the system.

### *Challenges/Risks*

**Assuring independence.** If the new independent body is decided to sit within an existing regulatory body, such as Ahpra, the independent role of the advisory body may conflict with this existing role as regulators. The process of assessing options for innovation may be better served by a separate independent body.

**Implementing recommendations of the advisory body.** In order for this independent body to meaningfully impact scope of practice, its advice should be pre-eminent in the subsequent consideration and determinations of the respective boards, accreditation authorities and jurisdictions. Its role should be well-understood by a range of institutions and decision-makers, involving a significant level of ongoing engagement.

**Complexity of continuous reform.** In a highly dispersed health care system, there will be complexity involved in communicating and implementing reforms based on a continuous improvement approach, ensuring all relevant services and workforce have received and acted on the most up to date reforms. Failing this, there is a potential risk around clarity of scope of practice.

### *Measuring success*

**Responsiveness of system to reform.** The time required to implement scope of practice changes is reduced.

**Best practice health workforce and services.** Australian primary health care services are demonstrated to operate in a way consistent with international best practice evidence and are responsive to continuous improvement.

**Public trust.** Consumers hold greater degree of trust in the health system due to its increased transparency and responsiveness to best practice evidence.

## Option 6: Harmonised Drugs and Poisons regulation to support a dynamic health system

### Summary

The primary health care system is governed by a patchwork of Commonwealth, state and territory legislation which combine to enable or restrict scope of practice. There are inconsistencies in the legislation and regulation on the same subject between jurisdictions. The legislation most often identified by stakeholders as having the greatest impact on scope of practice relates to Drugs and Poisons. This state-based legislation governs which professions can prescribe, dispense/supply and administer medicines, and under which circumstances.

### Inconsistency between state and territory Drugs and Poisons legislation

In implementing legislation on the subject of Drugs and Poisons, states and territories have subscribed to and broadly aligned to a consistent policy intent. However, because each legislation has been developed and implemented by separate jurisdictional processes, there is significant inconsistency in the detail between states and territories.

#### Insights from legislative and regulatory review

A review of all state and territory Drugs and Poisons legislation highlighted significant definitional inconsistency (i.e., 'health professional', 'authorised health professional', 'health practitioner', 'authorised practitioner', 'authorised health practitioner', 'a person', 'authorised person', and 'authorised prescriber' are each used across various Acts to refer to various subsets of health professions).

There is also significant inconsistency in terms of particular professions' authorisation to prescribe, supply/dispense and administer medicines between states and territories – for example, a podiatrist is authorised to prescribe unrestricted Schedule 8 (controlled drugs) in the Northern Territory but not explicitly authorised to do so in any other jurisdiction except Victoria, where a podiatrist may prescribe Schedule 4 and Schedule 8 medicines, but only in emergency scenarios and only with an authorisation granted under the relevant Victorian legislation.

This has the impact of restricting health professionals' ability to work in a consistent way across state and territory boundaries, either due to actual or perceived discrepancies in what is authorised. The complexity of the patchwork of legislation contributes significantly to a lack of clarity, potentially translating into incorrect assumptions of particular activities being unauthorised in some cases.

### Option for reform

The above policy issue can be addressed through the following option for reform, with interrelated reform options to enact broader harmonisation of legislation identified under the reform option to implement risk-based approaches to regulation.

## 6.1 Health Ministers Meeting agree to progress harmonisation of Drugs and Poisons legislation

Health Ministers Meeting agree to begin a body of work to progress harmonisation of Drugs and Poisons legislation. This would initiate a process of identification of inconsistencies in state and territory Drugs and Poisons legislation, and progress agreed amendments to increase consistency to the extent possible.

### *Implementation*

**Health Ministers Meeting initiate a process towards harmonisation.** Health Ministers Meeting agree to commence work to identify areas requiring greater consistency between state and territory Drugs and Poisons legislation. **(Short-term)**

**Identification and amendments to legislation that limits scope of practice.** State and territory Ministers work to identify and reach consensus about areas requiring increased consistency between Drugs and Poisons legislation. This should be performed as part of a larger body of work to identify and amend legislation that limits scope of practice, as a priority focus. **(Medium-term)**

**Harmonisation of legislation and regulation.** State and territory governments pursue harmonisation of Drugs and Poisons legislation to the extent possible in line with Ministerially agreed policy intent. **(Long-term)**

### *Intended Outcomes*

**Improved consistency of service delivery.** Health professionals work to a more consistent scope of practice between states and territory jurisdictions in terms of what medicines they are authorised to prescribe, dispense/supply, and administer. There is overall greater consistency at a system level in this area of scope of practice.

**Increased legislative clarity.** Removing undue complexity in the legislative environment in relation to Drugs and Poisons improves overall clarity of what health professionals are authorised to perform in specific circumstances. This helps to prevent scenarios where health professionals self-limit (or are limited by others) in what they can prescribe, dispense/supply, and administer because of lack of legislative clarity.

**Better alignment of Commonwealth and State/Territory powers.** Commonwealth policy and regulatory changes in relation to Therapeutic Goods and the PBS can be more readily and consistently enabled at a local jurisdictional level.

### *Stakeholder Impacts*

**Health professionals:** Greater flexibility to work in a consistent way across jurisdictions in gained, resulting in greater professional satisfaction compared to a situation of encountering arbitrary barriers.

**Consumers:** People accessing primary health care services to access medicines, including vaccination, gain greater clarity in who can provide what across different jurisdictions.

**Government:** State and territory governments gain greater consensus and consistency over their respective jurisdictional approaches to legislating scope of practice. Commonwealth



policy and regulatory changes in relation to Therapeutic Goods and the PBS can be more readily and consistently enabled at a local jurisdictional level.

## **Challenges/Risks**

**Lowest common denominator.** Concern was expressed by some stakeholders that harmonisation of Drugs and Poisons legislation would revert all jurisdictions to the lowest common denominator version of the legislation which may limit scope of practice in some areas.

**Reduced appetite to trial innovative programs.** A hypothetical case of highly harmonised state and territory legislation may reduce appetite for states and territories to introduce innovative program trials relating to Drugs and Poisons, such as pharmacist or paramedic prescribing trials underway in some jurisdictions. It should be noted that states and territories would maintain discrete Drugs and Poisons legislation under this reform option and would not remove actual opportunities to trial new programs.

**Complexity of implementation.** Each of the implementation options detailed in this reform option will require significant engagement in order to reach consensus between all decision-makers.

## **Measuring success**

**Increased harmonisation.** There is a greater degree of consistency in state and territory Drugs and Poisons legislation on an ongoing basis. Commonwealth policy and regulatory changes in relation to Therapeutic Goods and the PBS can be more readily and consistently enabled at a local jurisdictional level.

**Decreased barriers to scope of practice.** Health professionals experience fewer barriers to working to full scope of practice relating to drugs and poisons. More health professionals are enabled to work across state and territory borders.

### **Questions for further consultation: Legislation and regulation**

- Do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?
- To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?
- Are there specific policy actions related to legislation and regulation you believe should be pursued as part of the above options for reform?
- Are there implementation options which have not been considered which could progress the policy intent of these options for reform?
- Are there additional actions relating to leadership and culture which should be considered to encourage decision-makers (National Boards, state and territory governments) to work together in a cooperative way to achieve these policy options?

## 4c. Funding and payment policy

Two options for reform have been developed relating to the theme of funding and payment policy:

- Option 7: Funding and payment models incentivise multidisciplinary care teams working to full scope of practice
- Option 8: Direct referral pathways supported by technology

### Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice

#### Summary

Funding and payment models are a powerful determinant of health professionals' scope of practice. Rules which set which health professionals can be funded to deliver certain activities have a practical impact of limiting the scope of practice of those who are excluded, and the extent to which professionals collaborate as multidisciplinary care teams. The availability of appropriate and flexible funding is crucial to support health professionals working together and to their full scope of practice.

#### Issue 1: Flexible primary health care funding and payment models

Introducing more flexible payment models to complement the predominantly fee-for-service payment model in primary health care would support primary health care professionals to better meet consumers' changing health care needs (particularly complex or chronic health needs), as is the policy intent of My Medicare. This approach more effectively funds primary health care professionals and multidisciplinary care teams to work together, and individually, to their full scope of practice, and would particularly benefit regional and remote primary care where workforce is more limited.

#### Issue 2: Funding enablers for multidisciplinary care

The importance of the multidisciplinary care team has been recognised through government policy reforms such as Strengthening Medicare, the Workforce Incentive Program and PHN commissioning funds for multidisciplinary care. There is opportunity to further incentivise health professionals to work together to meet the needs of their patients by addressing barriers to multidisciplinary activities such as case conferencing and supporting access to specialist consultations for the primary health care team. Making the same funding available to deliver the same activity regardless of profession would also support the creation of more multidisciplinary care teams in primary care.

### Insights from consultation

Many stakeholders raised the good practice example of the New Zealand model of midwifery, which provides bundled funding to the parent to use across services. Bundled funding was by its proponents seen as a way of paying for the full scope of health professionals' skills and competency.

One consumer expressed concern for the funding arrangements available for health professionals:

*"Sometimes I feel there are frustrations in the scope of practice. It restricts health professionals like nurse practitioners and specialists. Places are underutilising talent they have. Reimbursement rates are sometimes the deciding factors for health professionals. Health professionals are sometimes discouraged from providing certain types of specialised care if they feel that the reimbursement rates are really low and they're not getting reimbursed as they should. This is particularly the case for a regional place like Wagga Wagga." – Consumer consultation participant*

### Options for reform

This reform option includes three mechanisms to better incentivise multidisciplinary care teams to work to full scope of practice.

#### 7.1. Using block, bundled and blended funding to deliver care flexibly, complementary to fee for service

This mechanism involves expanding alternative funding models to complement MBS funding, including a combination of different funding and payment types to support different types of care, increasing choice for primary health care services in how they are funded to meet community need. Definitions of funding types are as follows:

##### PRIMARY HEALTH CARE FUNDING AND PAYMENT 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.
- **Salaried workforce:** health professionals earn a salary rather than being funded through one of the above funding models.
- **Blended funding:** combination of funding and payment streams, such as block/bundled plus fee-for-service.

It is proposed to expand, refocus, cash out and blend a number of existing programs and payments into a flexible, broad-based, population specific and risk-based payment to support local access by consumers to care based on their needs. The new blended payment would be aligned with *Strengthening Medicare* reform direction of a primary health system serviced by multidisciplinary care teams working to their full scope of practice. This payment would be available to practices, practice groups and primary care provider organisations to fund and

support a flexible mix of health services to meet the local health needs of their enrolled population.

It would build on existing good practice examples of funding primary health care in rural and remote health settings e.g.,

- Section 19(2) exemptions (Health Insurance Act) whereby funding flows via authorised MBS billing to Local Health Networks (LHNs), and ACCHOs
- Block funding of:
  - Primary health care type services provided by LHNs through the National Health Reform Agreement (NHRA)
  - Aboriginal Community Controlled Health Organisations (ACCHOs) which provide effective culturally safe primary care under a blended (mix of MBS fee-for-service, grant and program funding)
  - PHN commissioning funds.

In-scope payment types for potential cashing out and incorporation into a new population focused, risk adjusted, broad based blended payment model could include the following:

- Workforce Incentive Program (WIP) [currently subject to the Review of General Practice Incentive Programs]
- Practice Incentive Payments (PIP) [currently subject to the Review of General Practice Incentives]
- MyMedicare benefits and incentives,
- PHN commissioning funds for services to support
  - Chronic Disease Management
  - Aged care
  - Multidisciplinary care (2023/24 Budget measure)
- S19 exemption payments (Health Insurance Act 1973)
- Chronic Disease Management (CDM) MBS items
- MBS special Aged Care items
- MBS Delegated (“for and on behalf of”) items
- Medication Review items.

To target and strengthen multidisciplinary care teams, the revised blended payment should be available to support access to a wider range of health professionals and services. This involves funding being made available to the GP, practice, practice groups and/or primary care provider organisations, responsible and accountable for initiating care, with funding flowing to other members of the multidisciplinary care team who deliver care autonomously, consistent with the plan and further guided by their specific scope of practice and ongoing assessment of care needs. In this way, the collective multidisciplinary care team is empowered to contribute to the overall care needs of the consumer and practice population.

Incorporating existing assessment and care coordination MBS items into the blended payment is intended to result in greater flexibility for multidisciplinary care teams operating across multiple sites.

Cashing out of the above existing payment and funding types, based on current and projected utilisation would then need to be adjusted prospectively to rectify historical, entrenched patterns of inequity and maldistribution of MBS and other payments in rural and underserved areas.

## **7.2. Single payment rate for specified activities falling within overlapping scope**

Within the existing MBS and other arrangements, it is proposed to adjust payment rates to introduce parity across professions undertaking effectively identical service delivery. This would apply to a limited number of specified activities which fall under the current scope of multiple professions. A priority example of existing practice is vaccination (delivered by various professions including medical, nursing and pharmacy and paid at different rates). Others include procedural items, such as catheterisation, cannulation, cervical screening and wound care. This may be achieved through either:

- Amendment of payment rates across comparable activities and items to introduce parity, or;
- Broader amendments to enable all health professionals acting within their scope of practice to claim the same payment rate for effectively identical activities. This would require amendment to the Health Insurance Act and associated MBS item codes but more aligned to a risk-based approach to regulating scope (refer [Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach](#)).

## **7.3. Bundled funding for midwifery continuity of care models**

Introduce bundled funding for the midwifery continuity of care model as a defined care pathway, to fund midwives to work to their full scope when they practise across different parts of the health care system (including primary and admitted care) which currently operate under separate funding arrangements.

## **Implementation**

**Introduce a new blended funding and payment model for primary health care multidisciplinary teams.** Payments should be based on specific areas of community need, be broad based and risk adjusted. Payment rules should not be overly prescriptive of target professions requiring legislative change and support relevant members of the multidisciplinary care team to provide care based on assessed local need, workforce capability / availability and the relevant, collective scope of practice of the care team. This new measure would be led by the Department of Health and Aged Care as a complement to existing mechanisms (My Medicare, WIP and PIP) to introduce additional flexibility over how care teams are funded. This may also warrant consideration as part of the current and ongoing NHRA reform priority negotiations. **(Medium term)**

**Review MBS and other payment rates** to review to determine which MBS items are shared or potentially shareable across multiple professions and consider opportunities to introduce parity. **(Medium term)**

**Design a model of bundled funding for midwifery continuity of care models.** Engage with midwifery and other peak bodies, jurisdictions, funders and consumers to design a model which is fit for purpose to support parents to access midwifery services across different parts of the health care system. The Independent Hospital and Aged Care Pricing

Authority (IHACPA) to recommence earlier exploratory work undertaken to develop a bundled payment model for midwifery continuity of care. **(Short-term)**

**Rural and remote program of delivery.** As a priority, engage states and territories, PHNs and providers to bring together a combination of the above funding policies for a concentrated launch for regional and remote regions (see Rural and remote considerations). **(Medium-term)**

### **Intended Outcomes**

**Greater flexibility over the makeup of the health care team.** Removing financial disincentives to services which can be provided by non-medical members of the care team, and addressing disparity in payments based on which health professional delivers the service, enhances opportunities for different health professionals to contribute to the health care team and work to their full scope of practice. Greater flexibility to form care teams with the right combination of scope and skills, including cross-service teams, built around the needs of the local practice population.

**Increased care team collaboration.** Funding the core aspects of multidisciplinary team-based care with an expanded, broad based blended payment model is intended to promote more collaborative approaches to care.

**Reduced reliance on highly episodic care.** Health professionals encounter fewer financial barriers to providing longer consultations or engaging in non-consumer-facing aspects of collaboration, care coordination and delivery, allowing them to work nearer to their full scope of practice.

### **Stakeholder Impacts**

**Health Service Providers:** Enabled to build more sustainable multidisciplinary primary health care teams which are genuinely collaborative and built around consumer need, without being limited by funding disparities which by proxy preference one health profession over another.

*“We’re advocating for more professions to be embedded in ACCHOs, for example pharmacists. It’s difficult to get us pharmacists into a setting outside of ‘normal’. In the Northern Territory if pharmacists were embedded in ACCHOs under supervision of a med practitioner or remote pharmacist, it would make a huge difference because we do have people who want to do the work but experience barriers.” – Darwin consultation participant*

**Health Professionals:** Improved valuing of the work multidisciplinary team members contribute, leading to enhanced employee satisfaction and retention.

Ability to receive consistent funding based on recognised skills and capabilities (refer [Option 1: National Skills and Capability Framework and Matrix](#)).

**Health Consumers:** Better able to access longer appointments and care which spans multiple disciplines, amounting to improved access and continuity of care.

## **Challenges/Risks**

**Impact of team culture and leadership.** Team members' ability to work to full scope of practice is partially dependent on team- and service-level culture and leadership. Funding for multidisciplinary care is assumed to be accepted in good faith and with the intent of genuinely enhancing multidisciplinary collaboration and opportunities within the team.

**Overly prescriptive payments.** It is important that proposed blended payment model allows for multidisciplinary care teams to be formed, and to deliver care, in a way that is responsive to consumer needs. Without an appropriate level of flexibility, multidisciplinary care teams may leave community needs unmet. If bundled funding is overly prescriptive in terms of included services, there is a potential risk of overservicing.

## **Measuring success**

**Improved consumer health outcomes** as consumers are better able to access primary health care services commensurate with their needs.

**More primary health care services take up block, blended and bundled funding** and offer multidisciplinary primary health care services to the community.

**More employment opportunities in primary health care services** for all primary health care professions. Teams work together in a demonstrably collaborative way by billing to relevant MBS item codes.

**Equity of access to primary care** regardless of location.



## Option 8: Direct referral pathways supported by technology

### Summary

Funding rules about which health professions can provide referrals to whom, and who can request diagnostic services, are tightly defined under the *Health Insurance Act 1973* (Health Insurance Act) and associated regulations. Under these funding rules, consumers referred to medical specialists or other health professionals, or for imaging or pathology, cannot receive MBS benefits for that service unless the referral was provided by a defined health professional under specified circumstances. These funding rules result in the majority of referrals being made by a GP.

#### Issue 1: Restrictive funding rules limiting direct referrals

The Review heard widespread practical examples of where referral to another health professional, or for imaging or pathology falls within a profession's scope of practice, but is limited by MBS funding rules. For example, it is within the competency and training of a physiotherapist to refer a consumer to an orthopaedic surgeon, but the consumer is currently required to access this referral via a GP. This may result in unnecessary duplicative service delivery and limits the extent to which a health professional can exercise their professional judgment i.e., work to their full scope of practice.

#### Insights from legislation and regulation review

A regulatory review found that funding rules which define the conditions under which referrals and requests can be funded are highly restrictive as defined under the Health Insurance Act. Stakeholder evidence indicates these rules act as a de facto authorising force to restrict some professionals' scope of practice in providing referrals they are competent to provide.

#### Issue 2: Referrals not adequately supported by technology

The current digital environment in primary health care does not allow timely visibility over transitions of care, including referrals. Published evidence highlights the importance of technology which facilitates communication between health professionals as an enabler of scope of practice. Stakeholder consultations discussed at length that the absence of a system-wide digital mechanism for referrals is an impediment to health professionals' ability to make and receive referrals, and to keep informed about the consumers' overall care journey across the multidisciplinary care team.

### Options for reform

This reform option includes two mechanisms to enable more health professions to work to full scope of practice by overseeing direct referrals.

#### 8.1. Amend funding regulation to reflect a broader range of circumstances where referrals can occur

A staged approach to expanding direct referrals would seek to address restrictive funding regulation, conditional on the following criteria being met:

- A. The referral is applicable to specific health professionals and circumstances, i.e., clearly linked to relevant health professional scope of practice;
- B. The referral is accompanied by appropriate, timely notification of the consultation to relevant treating team members including the patient's GP, which may include via digital mechanisms as available.

Additionally, the referring service and destination service should each be members of a multidisciplinary care team. This may take the form of a local community practice network or virtual team enabled by technology.

In the first instance, amendments to MBS would be pursued via amendments to legislative instruments made under the [Health Insurance Act](#) (Health Insurance Regulations 2018, the Health Insurance (General Medical Services Table) Regulations 2021 and the Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020). These amendments would seek to enable specific non-medical professionals to make direct referrals in specific circumstances. An initial cohort of health professionals and circumstances would be identified to whom referral authorities are to be extended, and MBS payment rules changed accordingly. Additional referral pathways may subsequently be considered for incorporation into the Act and MBS as deemed appropriate by decision-makers. Advice would also be sought from the Medical Review Advisory Committee (MRAC) and/or the Medical Services Advisory Committee (MSAC).

In the case a risk-based approach to regulation is adopted, there may be opportunities to shift over the medium term towards a more risk-based approach to defining where direct referrals fall under a health profession's scope of practice (refer [Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach](#)) rather than simply adding more named professions to regulations.

## 8.2. Implement parallel improvements to primary health digital infrastructure

The *National Digital Health Strategy* includes a priority to enable more timely and more automated information exchange across more primary health care professions. Recognising the role that interprofessional communication plays in enabling scope of practice, it is critical that this reform is undertaken with a view to contribute to direct referral mechanisms. Digital technology improvements will support both the effective functioning of multidisciplinary care teams and their capacity to adapt to new referral pathways.

### **Implementation**

**Identify first tranche of new direct referral pathways.** Professional associations and peak bodies will be tasked with identifying and agreeing a shortlist of referral pathways which clearly meet the conditions specified above. National Boards to be engaged to confirm scope requirements. This can be progressed via a direction from the HMM. **(Short-term)**

**Commonwealth, state and territory government and/or Ministerial Approval**, of the agreed amendments to the legislative instruments made under the Health Insurance Act (Health Insurance Regulations 2018, the Health Insurance (General Medical Services Table) Regulations 2021 and the Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020), as necessary. **(Medium-term)**

**Progress associated amendments to legislative instruments under the Health Insurance Act.** Make amendments to legislative instruments under the Health Insurance Act

according to the above approvals. Amendments to MBS items would flow from these amendments. **(Medium-term)**

## Intended Outcomes

**Increased collaboration.** Enhancing referral pathways is a critical component of facilitating multidisciplinary team-based care, allowing all members of the team to recognise both their own and other team members' scopes of practice and expertise (and their limits). Situating referrals within members of existing, established multidisciplinary care teams would forge stronger team-based relationships.

**Improved communication.** A standard solution for communications around referrals between members of the multidisciplinary care team would support interprofessional understanding and trust. With the right digital mechanism in place all members of the multidisciplinary care team to have visibility over the consumer's care pathway and each team members' role within it.

**More appropriate, timely referrals.** The intent of this reform option is to increase the number of access points by which each consumer can access referrals when required under specific circumstances.

### Insights from consultation

One medical professional representing a regional primary health service raised that some services which are GP-led could hypothetically be nurse-led were it not for scope of practice restrictions:

*"I was on a call with some psychiatrists about a system where physical health for [consumers with schizophrenia] could be looked after by a GP-led multidisciplinary care team – I said it doesn't need to be GP-led, could be nurse practitioner-led or nurse-led because we don't have enough GPs They can feed back things, order tests, etc, and free us up." – Tasmania consultation participant*

## Stakeholder Impacts

**Funders:** This reform option is expected to reduce duplicative episodes of care. While referrals made by some non-medical professions may increase, these are likely to replace referrals which would otherwise have been made by a GP and take place within existing appointments.

**Health Professionals:** Health professions to whom referral authorities are extended would have the opportunity to exercise their professional judgment to make referrals in a broader range of scenarios, resulting in improved professional satisfaction due to being enabled to complete the episode of care rather than requiring another health professional to do so unnecessarily.

GPs are expected to be less burdened by low-value episodes of care where the consumer seeking a referral has already been instructed to do so by a relevant health professional.

**Health Consumers:** Access to referrals is expected to improve, as more consumers can access an appropriate referral within an existing appointment, rather than requiring an additional episode of care via a GP or other referrer.

Affordability of accessing primary health care would likely improve accordingly. This is particularly salient for rural and remote consumers who may have limited access to referring health professionals.

## **Challenges/Risks**

**Pressure on the primary health system and MBS.** If referral authorities are extended broadly across professions, there is a risk of proliferation of referrals which may overburden services receiving referrals. There is an associated risk of a sharp increase in costs to the MBS, impacting overall system sustainability. A staged approach to this reform has been recommended to mitigate the potential risks of scaled-up implementation.

**Interprofessional trust and respect.** There is a risk that newly introduced referral pathways may not be understood or trusted, potentially not being accepted by the destination provider. This is partially rooted in interprofessional leadership and culture. Although digital pathways have the capacity to improve visibility and therefore trust between referral partners to some extent, there must also be an associated effort to facilitate interprofessional collaboration and mutual respect, as detailed in [Option 2: Develop primary health care capability](#) and [Option 3: Early career and ongoing professional development](#).

**Unnecessary referrals.** As consumers are expected to be able to access referrals more readily, there is a potential risk that consumers may be more likely to receive referrals that are not critical to their care. The proposed staged approach, that includes conditions for which a clear clinical pathway exists, is designed to mitigate this risk.

**Fragmentation of care.** Concerns were voiced through stakeholder consultation that this reform option may lead to fragmentation of care unless all members of the care team have good visibility over all referrals. For this reason, the digital mechanism is a critical component of the proposed reform. Clearly defined accountabilities accruing to the referring party (in terms of their indemnity coverage) will also be an important consideration.

## **Measuring success**

**More timely referrals corresponding to new direct referral pathways.** This will be indicated by an increase in the number of MBS claims for referrals made by health professionals who have gained MBS-funded direct referral pathways.

**Decreased burden on GPs and other existing referrers.** An associated decrease in the number of consumers presenting to GPs for the purpose of gaining a referral, for which they have already received advice from another health professional, is expected.

**More consistent communication between multidisciplinary care team members.** This will be enhanced by consistent use of digital mechanisms designed to support referral pathways when available.

**Case description: Streamlined direct referral process**

Should the reform option be adopted, health professionals, working to defined conditions, would be enabled to refer patients directly to another health professional and/or for pathology or diagnostic investigations. For example:

A consumer experiencing pain associated with an acute musculoskeletal injury visits their physiotherapist for assessment. The physiotherapist is enabled to refer the patient for diagnostic imaging and to an orthopaedic surgeon for their opinion on treatment options. This streamlined referral pathway includes digital notification of the consumer's home GP where available, but reduces the requirement to visit to the GP to obtain referrals. The result is a more efficient process and an improved consumer experience resulting from unnecessary GP visits and quicker access to required treatment.

**Questions for further consultation: Funding and payment policy**

- Do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?
- To what extent do you believe these policy options will help to drive the policy intent of the Review in supporting multidisciplinary care teams to work together to full scope of practice?
- Are there implementation options which have not been considered which could progress the policy intent of these options for reform?

## 5. Conclusions and next steps

The second round of consultation gathered significant perspectives to shape the Review in the coming phases. Stakeholders have consistently indicated support for safe and effective primary care delivered by highly functioning teams comprised of skilled and competent health professionals working to their full scope of practice. The need to place the consumer central to reform decisions, in support of patient-centred care was viewed as paramount.

Phase 2 of the Review highlighted a range of reforms that could enable the health professional to work to their full scope of practice, enable the collaborative healthcare team to provide optimal person-centred care and support the system to deliver best practice primary care.

Additional stakeholder consultation and opportunities for input into the Review will follow this Issues Paper, as illustrated in Figure 2.

**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 draft Final Report to Government.

**Priority areas for further exploration during Phase 3 include:**

- Testing, validating and refining options for reform and implementation pathways;
- Tailoring reform options for a rural and remote context;
- Ensuring reform options respond to the needs of First Nations communities and workforces;
- Consideration of additional policy areas requiring substantive attention in the final report.

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 evidence review. A final phase of 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.

The **Expert Advisory Committee (EAC)** convened to provide subject matter expertise, insights and advice throughout the Review will continue to meet and provide inputs into each upcoming Review Phase.

# Appendix A: Summary of Review of Legislation and Regulation

## Part 1 – Legislation and Regulation review detailed methodology

The legislation and regulation review followed the below methodology and yielded key insights, as set out below.

*Table 2 Legislative and regulatory review methodology and key findings*



ACTIVITY	METHODOLOGY	KEY INSIGHTS
1. Longlist identification	<p>A. Identifying areas of law which may either directly or indirectly limit primary health care scope of practice and developing a Long List of relevant Acts and Regulations.</p> <p>B. Testing the Long List against findings from stakeholder consultations and, using the <i>Pareto principle</i>, identifying selected areas of regulation with potentially the most significant practical impacts on scope of practice. In this context, the <i>Pareto principle</i> is to be understood as the observed principle that, although there are often many causes for any observed phenomenon, it is often the scenario where a small subset of those causes are responsible for the majority of the observed outcome. In the context of this legislation and regulation review, this has been applied to limit the identified legislation and regulation which is likely to have the most substantive impact on scope of practice.</p>	<p>A wide range of Commonwealth, state and territory legislation and regulation may directly or indirectly limit primary health care scope of practice (either purporting to limit scope or having a practical impact on scope of practice).</p> <p>The areas of legislation identified as potentially having the most significant impact on scope of practice (the <i>Pareto</i> group) are:</p> <ul style="list-style-type: none"> <li>i. <u><i>Health Practitioner Regulation National Law Act 2009</i></u> (Health Practitioner National Law, as applied in each state and territory);</li> <li>ii. Drugs and poisons legislation in each jurisdiction;</li> <li>iii. Mental health legislation in each jurisdiction; and</li> <li>iv. Commonwealth MBS funding legislation.</li> </ul> <p>See Part 2 – Long List of Legislation and Regulation which either directly or indirectly impacts Scope of Practice for the full longlist.</p>
2. High level review of selected areas of legislation to determine the <i>Pareto</i> group	<p>A. Review of each subject of legislation for high-level indication of impact on scope of practice (e.g. level of specificity of named professions, settings, etc; references to National Law).</p>	<p>The review of the Health Practitioner National Law revealed that, despite some variation in its application between jurisdictions, it broadly acts as an enabler of scope of practice for those professions which fall under its jurisdiction (i.e. those working in registered health professions, such as midwifery, pharmacy and podiatry).</p> <p>The initial review of Drugs and Poisons legislation in each jurisdiction found inconsistency between states and territories' definitions of key terms and the invocation of the</p>

ACTIVITY	METHODOLOGY	KEY INSIGHTS
		<p>National Law, which could have a material impact on scope of practice. <i>(See findings for (3) below).</i></p> <p>The initial review of Commonwealth MBS funding legislation found a significant level of specificity which was likely to materially impact scope of practice in a number of ways. <i>(See findings for (4) below.)</i></p> <p>The initial review of mental health legislation in each jurisdiction revealed that it is not likely to significantly impact scope of practice at the primary health level. The mental health legislation was found to relate predominantly to acute and forensic mental health care. Use of named professions was not considered as limiting to scope as the Commonwealth MBS funding legislation.</p>
3. Targeted mapping and analysis of state and territory drugs and poisons regulations (from the <i>Pareto</i> group)	<p>Targeted mapping and analysis of state and territory drugs and poisons legislation, seeking to indicate areas of inconsistency and to ascertain how references to the National Law may have a (practically) limiting impact on scope of practice. To do this, the following steps were undertaken:</p> <ol style="list-style-type: none"> <li>1. <b>Application of Poisons Standard in each state and territory:</b> Mapping how each state and territory has approached the scheduling of drugs and poisons in accordance with the national Poisons Standard made under the Commonwealth Therapeutic Goods Act 1989. This exercise aided in the understanding that Schedules 1 (NSW only), 2, 3, 4 and 8 (all jurisdictions) are the schedules which relate to “medicines” and which are relevant</li> </ol>	<p>There is significant definitional variation between state and territory legislation, driving complexity around what health professionals are authorised to undertake when working across different states and territories. This is despite all states and territories ascribing to a consistent policy intent in developing their respective Drugs and Poisons legislation and adopting the national Poisons Standard made under the Commonwealth Therapeutic Goods Act 1989.</p> <p>States’ and territories’ respective Drugs and Poisons Acts are substantively silent on references to self-regulated professions, due largely to how these Acts define the term ‘health practitioner’ with reference to the National Law. This precludes self-regulated professions from the definition and,</p>

ACTIVITY	METHODOLOGY	KEY INSIGHTS
	<p>to the domains of competency in-scope for this Review (i.e. ‘possessing’, ‘administering’, ‘supplying’ and ‘prescribing’).</p> <p>2. <b>Definition of key terms:</b> Mapping the similarities and differences between how each state and territory define key terms and concepts related to primary health care, including the definitions of “health practitioner” and each domain of competency. Part 3 - Definition Analysis Drugs and Poisons of this Appendix provides an overview of this high-level definitional analysis.</p> <p>3. <b>Mapping of legislation in respect of each domain of competency:</b> Within each of the jurisdictions, the relevant legislation and regulation was mapped to understand which provisions may limit scope of primary health care practitioners. This was done by searching within the legislation and regulation the relevant domain of competency being regulated (for example, ‘supplying’), identifying the relevant health practitioners captured by the provision, and which medicines are captured by the provision. This output, and how it is relevant to scope of practice is shown in Part 4 – Drugs and Poisons Mapping of this Appendix.</p> <p>Note: to achieve a high-level understanding of how these drugs and poisons legislation and regulation limit scope of practice, whilst limiting the particular scope of this task, only certain primary health care professions were considered ‘in scope’ for this mapping exercise. These professions are listed in each table in Part 4 – Drugs and Poisons Mapping.</p>	<p>consequently, from having legislative authority to deal with Drugs and Poisons in each jurisdiction.</p>

ACTIVITY	METHODOLOGY	KEY INSIGHTS
<p>4. Targeted mapping and analysis of <u>Health Insurance Act 1973 (Cth)</u> and associated legislative instruments (from the <i>Pareto</i> group)</p>	<p>A targeted review of the <u>Health Insurance Act 1973 (Cth)</u> and associated legislative instruments (<u>the Health Insurance Regulations 2018</u>, the <u>Health Insurance (General Medical Services Table) Regulations 2021</u> and the <u>Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020</u>) to validate hypotheses developed through analysis of Phase 2 evidence.</p> <p>This review had a particular focus on:</p> <ul style="list-style-type: none"> <li>A. Limitations on which health professionals can refer patients to other health professionals or request R-type diagnostic imaging services for patients under the MBS. Targeted review considered the below case studies under the Act: <ul style="list-style-type: none"> <li>1) Dietitian <ul style="list-style-type: none"> <li>a) Refer to pathology</li> <li>b) Refer to another health practitioner</li> </ul> </li> <li>2) Physiotherapist <ul style="list-style-type: none"> <li>a) Refer to imaging</li> <li>b) Refer to an orthopaedic surgeon</li> </ul> </li> <li>3) Pharmacist <ul style="list-style-type: none"> <li>a) Refer to pathology</li> </ul> </li> </ul> </li> <li>B. Ability of nurses to deliver mental health care services in the community under the MBS. Targeted review considered the ability of Registered Nurses to diagnose and treat mental health conditions under the <u>Health Insurance Act 1973 (Cth)</u>.</li> <li>C. Inconsistencies in the fees prescribed for MBS services undertaken by different health professionals. Targeted review was undertaken into the <u>Health Insurance (General Medical Services Table) Regulations 2021</u> and <u>Health Insurance (Section 3C</u></li> </ul>	<p>The <u>Health Insurance Act 1973</u> (hereafter 'Health Insurance Act'), and its associated legislative instruments (regulations and determinations), while not primarily intended to regulate scope, are so highly prescriptive about what can be funded and who can access MBS-funded services that they have a significant (practical) impact on scope of practice.</p> <p>There is a high degree of specificity in the Health Insurance Act in relation to referrals to other health professionals or to request pathology or imaging for patients under the MBS. A highly constrained group of health professionals can make referrals to highly specific types of specialist services as a condition for the consumer to access the MBS rebate.</p> <p>There is no MBS-funded pathway for Registered Nurses to conduct attendances for patients (including for the purposes of assessing mental health care needs and instigating a mental health care plan).</p> <p>There is significant disparity between MBS rates for different professions for broadly comparable services, notwithstanding that a direct comparison between services performed by different health professionals was not possible in all cases.</p>

ACTIVITY	METHODOLOGY	KEY INSIGHTS
	<p><u>Midwife and Nurse Practitioner Services)</u>  <u>Determination 2020</u> to reach a comparison of fees for comparable services between:</p> <ul style="list-style-type: none"> <li>i. GP and Prescribed Medical Practitioner.</li> <li>ii. GP and Nurse practitioner to the extent possible.</li> </ul>	

## Part 2 – Long List of Legislation and Regulation which either directly or indirectly impacts Scope of Practice

The Long List component of the legislative and regulative review identifies Acts and Regulations, regulating a range of subject areas, which may directly or indirectly limit primary health care scope of practice (either by purporting to limit scope or directly or by having a practical impact on scope of practice due to the way that another subject area is regulated). The Long List has been tested against the findings from stakeholder consultations to identify the areas of legislation with potentially the most significant practical impacts on scope of practice (using the Pareto principle).

Table 3 below outlines identified legislative and regulative instruments with the following components:

- 1) Instrument: the name of the legislation or regulation
- 2) Jurisdiction: which Australian jurisdiction the instrument applies to
- 3) Regulation of scope of practice: whether the instrument regulates scope indirectly (practical impact on scope of practice or directly (purporting to limit scope)
- 4) Subject: the general subject matter of the instrument, taken – where possible – from the Object / Purpose clause of the relevant Act or Regulation. Note: the object / purpose provision in a piece of legislation serves a particular function in statutory interpretation and is not sufficient, nor intended, to provide a holistic or comprehensive explanation of the contents of the relevant legislation. Rather, in this Longlist, the object / purpose provision of each piece of legislation has been included only to provide an indicative overview of what each piece of legislation purports to do, in lieu of each piece of legislation being subject to detailed mapping.

The table is ordered by jurisdiction, starting with Commonwealth jurisdiction. The instruments have then been ordered alphabetically within each jurisdiction.

Table 3 Legislation and regulation Review - Long List

Instrument	Regulation of Scope of Practice	Subject
<b>Commonwealth</b>		
<i>A New Tax System (Goods and Services Tax) Act 1999</i>	Indirect	Funding, insurances, and tax
<i>A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Act 1999</i>	Indirect	Funding, insurances, and tax
<i>Aged Care Act 1997</i>	Indirect	Funding, insurances, and tax
<i>Aged Care Act 1997</i>	Indirect	Hospital and health services (aged care)
<i>Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006</i>	Indirect	Veterans' healthcare & compensation entitlements
<i>Australian Radiation Protection and Nuclear Safety Act 1998</i>	Indirect	Radiation safety

Instrument	Regulation of Scope of Practice	Subject
<i>Australian Radiation Protection and Nuclear Safety Regulations 2018</i>	Indirect	Radiation safety
<i>Biosecurity Act 2015</i>	Indirect	Public health
<i>Euthanasia Laws Act 1997</i>	Indirect	Voluntary assisted dying
<i>Fringe Benefits Tax Assessment Act 1986</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance (General Medical Services Table) Regulations 2021</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance (Pathology Services Table) Regulations 2021</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance (Professional Services Review Scheme) Regulations 2019</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance Act 1973</i>	Indirect	Funding, insurances, and tax
<i>Health Insurance Regulations 2018</i>	Indirect	Funding, insurances, and tax
<i>Insurance Contracts Act 1984</i>	Indirect	Funding, insurances, and tax
<i>Medical Indemnity Act 2002</i>	Indirect	Funding, insurances, and tax
<i>Medicare Levy Act 1986</i>	Indirect	Funding, insurances, and tax
<i>Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Military Rehabilitation and Compensation (Consequential and Transitional Provisions) Act 2004</i>	Indirect	Veterans' healthcare & compensation entitlements
<i>Military Rehabilitation and Compensation Act 2004</i>	Indirect	Veterans' healthcare & compensation entitlements
<i>Mutual Recognition Act 1992</i>	Indirect	Workforce mobility (within Australia)
<i>National Disability Insurance Scheme Act 2013</i>	Indirect	Funding, insurances, and tax
<i>National Disability Insurance Scheme Act 2013</i>	Indirect	Funding, insurances, and tax
<i>National Health (Listing of Pharmaceutical Benefits) Instrument 2012</i>	Indirect	Funding, insurances, and tax
<i>National Health (Pharmaceutical Benefits) Regulation 2017</i>	Indirect	Funding, insurances, and tax
<i>National Health (Pharmaceuticals and Vaccines - Cost Recovery) Regulations 2022</i>	Indirect	Funding, insurances, and tax



Instrument	Regulation of Scope of Practice	Subject
<i>National Health (Pharmaceutical benefits - early supply) Instrument 2015</i>	Indirect	Funding, insurances, and tax
<i>National Health (Supply of Pharmaceutical Benefits - Under Co-payment Data and Claims for Payment) Rules 2022</i>	Indirect	Funding, insurances, and tax
<i>National Health Act 1953</i>	Indirect	Funding, insurances, and tax
<i>National Health Act 1953</i>	Indirect	Hospital and health services
<i>National Health Reform Act 2011</i>	Indirect	Funding, insurances, and tax
<i>National Health Regulation 2016</i>	Indirect	Funding, insurances, and tax
<i>Private Health Insurance (Prudential Supervision) Act 2015</i>	Indirect	Funding, insurances, and tax
<i>Private Health Insurance Act 2007</i>	Indirect	Funding, insurances, and tax
<i>Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988</i>	Indirect	Veterans' healthcare & compensation entitlements
<i>Safety, Rehabilitation and Compensation Act 1988</i>	Indirect	Workplace health and safety and compensation
<i>Taxation Administration Act 1953</i>	Indirect	Funding, insurances, and tax
<i>Therapeutic Goods (Medical Devices) Regulations 2022</i>	Indirect	Therapeutic goods
<i>Therapeutic Goods (Poisons Standard - February 2024) Instrument 2024 (Poisons Standard)</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Therapeutic Goods Act 1989</i>	Indirect	Public health
<i>Therapeutic Goods Act 1989</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Therapeutic Goods Act 1989</i>	Indirect	Therapeutic goods
<i>Therapeutic Goods Regulation 1990</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Therapeutic Goods Regulation 1990</i>	Indirect	Therapeutic goods
<i>Trans-Tasman Mutual Recognition Act 1997</i>	Indirect	Workforce mobility (between Australia and New Zealand)
<i>Treatment Benefits (Special Access) Act 2019</i>	Indirect	Veterans' healthcare & compensation entitlements
<i>Veterans' Entitlements Act 1986</i>	Indirect	Veterans' healthcare & compensation entitlements

Instrument	Regulation of Scope of Practice	Subject
<i>Work Health and Safety Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulations 2011</i>	Indirect	Workplace health and safety and compensation
<b>Australian Capital Territory</b>		
<i>Births, Deaths and Marriages Registration Act 1997</i>	Indirect	Ancillary or related functions
<i>Children and Young People Act 2008</i>	Indirect	Social work (to the extent it applies to children)
<i>Crimes Act 1900</i>	Indirect	Criminal activity
<i>Emergencies Act 2004</i>	Direct	Ambulance and Emergency Health Services
<i>Emergencies Regulation 2004</i>	Direct	Ambulance and Emergency Health Services
<i>Health Act 1993</i>	Indirect	Hospital and health services
<i>Health Act 1993</i>	Indirect	Public health
<i>Health Act 1993</i>	Indirect	Termination of pregnancy
<i>Health Practitioner Regulation National Law (ACT) Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (ACT) Act 2010</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (ACT) Act 2010</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018 (ACT)</i>	Direct	Scope of practice
<i>Insurance Authority Act 2005</i>	Indirect	Funding, insurances, and tax
<i>Medical Treatment (Health Directions) Act 2006</i>	Indirect	Ancillary or related functions
<i>Medicines, Poisons and Therapeutic Goods Act 2008</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines, Poisons and Therapeutic Goods Act 2008</i>	Indirect	Therapeutic goods
<i>Medicines, Poisons and Therapeutic Goods Regulation 2008</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines, Poisons and Therapeutic Goods Regulation 2008</i>	Indirect	Therapeutic goods
<i>Mental Health Act 2015</i>	Indirect	Mental health
<i>Public Health Act 1997</i>	Indirect	Public health
<i>Public Health Regulation 2000</i>	Indirect	Public health

Instrument	Regulation of Scope of Practice	Subject
<i>Radiation Protection Act 2006</i>	Indirect	Radiation safety
<i>Radiation Protection Regulation 2007</i>	Indirect	Radiation safety
<i>Road Transport (Alcohol and Drugs) Act 1977</i>	Indirect	Ancillary or related functions
<i>Work Health and Safety Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulation 2011</i>	Indirect	Workplace health and safety and compensation
<i>Workers Compensation Act 1951</i>	Indirect	Workplace health and safety and compensation
<i>Workers Compensation Regulation 2002</i>	Indirect	Workplace health and safety and compensation
<b>New South Wales</b>		
<i>Abortion Law Reform Act 2019</i>	Indirect	Termination of pregnancy
<i>Assisted Reproductive Technology Act 2007</i>	Indirect	Hospital and health services
<i>Assisted Reproductive Technology Regulation 2014</i>	Indirect	Hospital and health services
<i>Crimes Act 1900</i>	Indirect	Criminal activity
<i>Crimes Regulation 2020</i>	Indirect	Criminal activity
<i>Health Care Liability Act 2001</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (Adoption of National Law) Act 2009</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (Adoption of National Law) Act 2009</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (Adoption of National Law) Act 2009</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018 (NSW)</i>	Direct	Scope of practice
<i>Health Services Act 1997</i>	Indirect	Hospital and health services
<i>Health Services Regulation 2018</i>	Indirect	Hospital and health services
<i>Mental Health Act 2007</i>	Indirect	Mental health
<i>Mental Health Regulation 2019</i>	Indirect	Mental health
<i>Poisons and Therapeutic Goods Act 1966</i>	Indirect	Scheduling and dealing with drugs and poisons

Instrument	Regulation of Scope of Practice	Subject
<i>Poisons and Therapeutic Goods Act 1966</i>	Indirect	Therapeutic goods
<i>Poisons and Therapeutic Goods Regulation 2008</i> [This legislation is currently due to be automatically repealed under the Subordinate Legislation Act 1989 on 1 September 2024]	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons and Therapeutic Goods Regulation 2008</i> [This legislation is currently due to be automatically repealed under the Subordinate Legislation Act 1989 on 1 September 2024]	Indirect	Therapeutic goods
<i>Private Health Facilities Act 2007</i>	Indirect	Hospital and health services
<i>Private Health Facilities Regulation 2017</i>	Indirect	Hospital and health services
<i>Protection from Harmful Radiation Act 1990</i>	Indirect	Radiation safety
<i>Protection from Harmful Radiation Regulation 2013</i>	Indirect	Radiation safety
<i>Public Health Act 2010</i>	Indirect	Public health
<i>Public Health Regulation 2022</i>	Indirect	Public health
<i>Voluntary Assisted Dying Act 2022</i>	Indirect	Voluntary assisted dying
<i>Work Health and Safety Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulation 2017</i>	Indirect	Workplace health and safety and compensation
<i>Workers Compensation Act 1987</i>	Indirect	Workplace health and safety and compensation
<i>Workers Compensation Regulation 2016</i>	Indirect	Workplace health and safety and compensation
<i>Workplace Injury Management and Workers Compensation Act 1988</i>	Indirect	Workplace health and safety and compensation
<b>Northern Territory</b>		
<i>Care and Protection of Children Act 2007</i>	Indirect	Hospital and health services
<i>Criminal Code Act 1983</i>	Indirect	Criminal activity
<i>Health and Community Services Complaints Act 1998</i>	Indirect	Hospital and health services
<i>Health and Community Services Complaints Regulation 1998</i>	Indirect	Hospital and health services
<i>Health Practitioner Regulation (National Uniform Legislation) Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation (National Uniform Legislation) Act 2010</i>	Direct	Scope of practice

Instrument	Regulation of Scope of Practice	Subject
<i>Health Practitioner Regulation (National Uniform Legislation) Act 2010</i>	Indirect	Workforce mobility
<i>Health Practitioners Act 2004</i>	Indirect	Hospital and health services
<i>Health Practitioners Act 2004</i>	Direct	Scope of practice
<i>Health Practitioners Act 2004</i>	Indirect	Workforce mobility
<i>Health Service Act 2021</i>	Indirect	Hospital and health services
<i>Medicines, Poisons and Therapeutic Goods Act 2012</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines, Poisons and Therapeutic Goods Act 2012</i>	Indirect	Therapeutic goods
<i>Medicines, Poisons and Therapeutic Goods Regulations 2014</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines, Poisons and Therapeutic Goods Regulations 2014</i>	Indirect	Therapeutic goods
<i>Mental Health and Related Services Act 1998</i>	Indirect	Mental health
<i>Mental Health and Related Services Regulations 2009</i>	Indirect	Mental health
<i>Public and Environmental Health Act 2011</i>	Indirect	Public health
<i>Public and Environmental Health Regulations 2014</i>	Indirect	Public health
<i>Radiation Protection Act 2004</i>	Indirect	Radiation safety
<i>Radiation Protection Regulations 2007</i>	Indirect	Radiation safety
<i>Termination of Pregnancy Law Reform Act 2017</i>	Indirect	Termination of pregnancy
<i>Termination of Pregnancy Law Reform Regulation 2017</i>	Indirect	Termination of pregnancy
<i>Work Health Administration Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety (National Uniform Legislation) Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety (National Uniform Legislation) Regulations 2011</i>	Indirect	Workplace health and safety and compensation
<b>Queensland</b>		
<i>Ambulance Service Act 1991</i>	Direct	Ambulance and Emergency Health Services
<i>Ambulance Service Regulation 2015</i>	Direct	Ambulance and Emergency Health Services
<i>Criminal Code Act 1899</i>	Indirect	Criminal activity
<i>Health Practitioner Regulation National Law (Queensland) Act 2019</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (Queensland) Act 2019</i>	Direct	Scope of practice

Instrument	Regulation of Scope of Practice	Subject
<i>Health Practitioner Regulation National Law (Queensland) Act 2019</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018 (Qld)</i>	Direct	Scope of practice
<i>Health Transparency Act 2019</i>	Indirect	Hospital and health services
<i>Health Transparency Regulation 2020</i>	Indirect	Hospital and health services
<i>Hospital and Health Boards Act 2011</i>	Indirect	Hospital and health services
<i>Hospital and Health Boards Regulation 2023</i>	Indirect	Hospital and health services
<i>Medicines and Poisons (Medicines) Regulation 2021</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines and Poisons (Poisons and Prohibited Substances) Regulation 2021</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines and Poisons Act 2019</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Mental Health Act 2016</i>	Indirect	Mental health
<i>Mental Health Regulation 2017</i>	Indirect	Mental health
Nursing and Midwifery Workload Management Standard (statutory instrument made under the Hospital and Health Boards (Nursing and Midwifery Workload Management Standard) Notice 2016	Indirect	Hospital and health services
<i>Public Health Act 2005</i>	Indirect	Public health
<i>Public Health Regulation 2018</i>	Indirect	Public health
<i>Radiation Safety Act 1999</i>	Indirect	Radiation safety
<i>Radiation Safety Regulation 2010</i>	Indirect	Radiation safety
<i>Termination of Pregnancy Act 2018</i>	Indirect	Termination of pregnancy
<i>Therapeutic Goods Act 2019</i>	Indirect	Therapeutic goods
<i>Therapeutic Goods Regulation 2021</i>	Indirect	Therapeutic goods
<i>Voluntary Assisted Dying Act 2021</i>	Indirect	Voluntary assisted dying
<i>Voluntary Assisted Dying Regulation 2022</i>	Indirect	Voluntary assisted dying
<i>Work Health and Safety (Codes of Practice) Notice 2022</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Act 2011</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulation 2011</i>	Indirect	Workplace health and safety and compensation



Instrument	Regulation of Scope of Practice	Subject
<i>Workers' Compensation and Rehabilitation Act 2003</i>	Indirect	Workplace health and safety and compensation
<i>Workers' Compensation and Rehabilitation Regulation 2014</i>	Indirect	Workplace health and safety and compensation
<b>South Australia</b>		
<i>Controlled Substances (Poisons) Regulations 2011</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Controlled Substances Act 1984</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Controlled Substances Act 1984</i>	Indirect	Therapeutic goods
<i>Criminal Law Consolidation (General) Regulations 2021</i>	Indirect	Criminal activity
<i>Criminal Law Consolidation Act 1935</i>	Indirect	Criminal activity
<i>Health and Community Services Complaints Act 2004</i>	Indirect	Hospital and health services
<i>Health and Community Services Complaints Regulations 2019</i>	Indirect	Hospital and health services
<i>Health Care Act 2008</i>	Indirect	Hospital and health services (including emergency and ambulance services)
<i>Health Care Regulations 2023</i>	Indirect	Hospital and health services
<i>Health Practitioner Regulation National Law (South Australia) Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (South Australia) Act 2010</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (South Australia) Act 2010</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law (South Australia) Regulations 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (South Australia) Regulations 2010</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (South Australia) Regulations 2010</i>	Indirect	Workforce mobility
<i>Health Services Charitable Gifts Act 2011</i>	Indirect	Hospital and health services
<i>Health Services Charitable Gifts Regulations 2011</i>	Indirect	Hospital and health services
<i>Mental Health Act 2009</i>	Indirect	Mental health
<i>Mental Health Regulations 2010</i>	Indirect	Mental health
<i>Radiation Protection and Control Act 2021</i>	Indirect	Radiation safety
<i>Radiation Protection and Control Regulations 2022</i>	Indirect	Radiation safety
<i>Return to Work Corporation of South Australia Act 1994</i>	Indirect	Workplace health and safety and compensation



Instrument	Regulation of Scope of Practice	Subject
<i>Social Workers Registration Act 2021</i> <b>[NB This legislation does not commence until 1 July 2025 or otherwise by proclamation: s 2]</b>	Direct	Scope of practice - social workers
<i>South Australian Public Health (General) Regulations 2013</i>	Indirect	Public health
<i>South Australian Public Health (Notifiable and Controlled Notifiable Conditions) Regulations 2012</i>	Indirect	Public health
<i>South Australian Public Health (Notifiable Contaminants) Regulations 2020</i>	Indirect	Public health
<i>South Australian Public Health Act 2011</i>	Indirect	Public health
<i>Termination of Pregnancy Act 2021</i>	Indirect	Termination of pregnancy
<i>Termination of Pregnancy Regulations 2022</i>	Indirect	Termination of pregnancy
<i>Voluntary Assisted Dying Act 2021</i>	Indirect	Voluntary assisted dying
<i>Voluntary Assisted Dying Regulation 2022</i>	Indirect	Voluntary assisted dying
<i>Work Health and Safety Act 2012</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulations 2012</i>	Indirect	Workplace health and safety and compensation
<b>Tasmania</b>		
<i>Ambulance Service (Paramedic) Regulations 2014</i>	Direct	Ambulance and Emergency Health Services
<i>Ambulance Service Act 1982</i>	Direct	Ambulance and Emergency Health Services
<i>Criminal Code Act 1924</i>	Indirect	Criminal activity
<i>End-of-Life Choices (Voluntary Assisted Dying) Act 2021</i>	Indirect	Voluntary assisted dying
<i>End-of-Life Choices (Voluntary Assisted Dying) Regulations 2022</i>	Indirect	Voluntary assisted dying
<i>Health Complaints Act 1995</i>	Indirect	Hospital and health services
<i>Health Practitioner Regulation National Law (Tasmania) Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (Tasmania) Act 2010</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (Tasmania) Act 2010</i>	Indirect	Workforce mobility
<i>Health Professionals (Special Events Exemption) Act 1998</i>	Direct	Scope of practice
<i>Health Service Establishments Act 2006</i>	Indirect	Hospital and health services
<i>Mental Health Act 2013</i>	Indirect	Mental health

Instrument	Regulation of Scope of Practice	Subject
<i>Poisons (Adoption of Uniform Standard) Order 2012</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Application of Uniform Standard) Order 2021</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Declared Restricted Substances) Order 2017</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Drugs of Dependence) Order 2009</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Interim Authorisation) Order 2023 [NB expires 5 June 2024]</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Midwifery Substances) Order 2011</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons (Notifiable Restricted Substances) Order 2009</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons Act 1971</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Poisons Regulation 2018</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Public Health Act 1997</i>	Indirect	Public health
<i>Radiation Protection Act 2005</i>	Indirect	Radiation safety
<i>Radiation Protection Regulations 2016</i>	Indirect	Radiation safety
<i>Reproductive Health (Access to Terminations) Act 2013</i>	Indirect	Termination of pregnancy
<i>Reproductive Health (Access to Terminations) Regulations 2024</i>	Indirect	Termination of pregnancy
<i>Tasmanian Health Service Act 2018</i>	Indirect	Hospital and health services
<i>Tasmanian Health Service Regulations 2018</i>	Indirect	Hospital and health services
<i>Therapeutic Goods Act 2001</i>	Indirect	Therapeutic goods
<i>Therapeutic Goods Regulations 2022</i>	Indirect	Therapeutic goods
<i>Work Health and Safety Act 2012</i>	Indirect	Workplace health and safety and compensation
<i>Work Health and Safety Regulation 2022</i>	Indirect	Workplace health and safety and compensation
<i>Workers Rehabilitation and Compensation Act 1988</i>	Indirect	Workplace health and safety and compensation
<i>Workers Rehabilitation and Compensation Regulations 2021</i>	Indirect	Workplace health and safety and compensation
<b>Victoria</b>		
<i>Abortion Law Reform Act 2008</i>	Indirect	Termination of pregnancy
<i>Ambulance Services Act 1986</i>	Direct	Ambulance and Emergency Health Services
<i>Crimes Act 1958</i>	Indirect	Criminal activity

Instrument	Regulation of Scope of Practice	Subject
<i>Drugs, Poisons and Controlled Substances Act 1981</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Drugs, Poisons and Controlled Substances Regulations 2017</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Health Complaints Act 2016</i>	Indirect	Hospital and health services
<i>Health Complaints Regulations 2019</i>	Indirect	Hospital and health services
<i>Health Practitioner Regulation National Law (Victoria) Act 2009</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (Victoria) Act 2009</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (Victoria) Act 2009</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018 (Vic)</i>	Direct	Scope of practice
<i>Health Services (Health Service Establishments) Regulations 2013</i>	Indirect	Hospital and health services
<i>Health Services (Quality and Safety) Regulations 2020</i>	Indirect	Hospital and health services
<i>Health Services Act 1988</i>	Indirect	Hospital and health services
<i>Mental Health and Wellbeing Act 2022</i>	Indirect	Mental health
<i>Mental Health and Wellbeing Regulations 2023</i>	Indirect	Mental health
<i>Mental Health and Wellbeing Transitional Regulations 2023 [NB to be revoked on 1 September 2025]</i>	Indirect	Mental health
<i>Occupational Health and Safety Act 2004</i>	Indirect	Hospital and health services
<i>Pharmacy Regulation Act 2010</i>	Direct	Pharmaceutical services
<i>Public Health and Wellbeing Act 2008</i>	Indirect	Public health
<i>Public Health and Wellbeing Act 2008</i>	Indirect	Public health
<i>Public Health and Wellbeing Regulations 2019</i>	Indirect	Public health
<i>Radiation Act 2005</i>	Indirect	Radiation safety
<i>Radiation Regulations 2017</i>	Indirect	Radiation safety
<i>Therapeutic Goods (Victoria) Act 2010</i>	Indirect	Therapeutic goods
<i>Voluntary Assisted Dying Act 2017</i>	Indirect	Voluntary assisted dying
<i>Voluntary Assisted Dying Regulations 2018</i>	Indirect	Voluntary assisted dying
<i>Workers Compensation Act 1958</i>	Indirect	Workplace health and safety and compensation

Instrument	Regulation of Scope of Practice	Subject
<i>Workplace Injury Rehabilitation and Compensation Act 2013</i>	Indirect	Workplace health and safety and compensation
<i>Workplace Injury Rehabilitation and Compensation Regulation 2014</i>	Indirect	Workplace health and safety and compensation
<b>Western Australia</b>		
<i>Blood and Tissue (Transmissible Diseases) Regulation 1985</i>	Indirect	Public health
<i>Criminal Code Act Compilation Act 1913</i>	Indirect	Criminal activity
<i>Health (Miscellaneous Provisions) Act 1911</i>	Indirect	Public health
<i>Health Act 2011</i>	Indirect	Termination of pregnancy
<i>Health Practitioner Regulation National Law (WA) Act 2010</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law (WA) Act 2010</i>	Direct	Scope of practice
<i>Health Practitioner Regulation National Law (WA) Act 2010</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Funding, insurances, and tax
<i>Health Practitioner Regulation National Law Regulation 2018</i>	Indirect	Workforce mobility
<i>Health Practitioner Regulation National Law Regulation 2018 (WA)</i>	Direct	Scope of practice
<i>Health Services (General) Regulations 2019</i>	Indirect	Hospital and health services
<i>Health Services (Information) Regulations 2017</i>	Indirect	Hospital and health services
<i>Health Services Act 2016</i>	Indirect	Hospital and health services
<i>Medicines and Poisons (Validation) Act 2022</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines and Poisons Act 2014</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Medicines and Poisons Regulations 2016</i>	Indirect	Scheduling and dealing with drugs and poisons
<i>Mental Health Act 2014</i>	Indirect	Mental health
<i>Mental Health Regulations 2015</i>	Indirect	Mental health
<i>Public Health Act 2016</i>	Indirect	Public health
<i>Public Health Regulations 2017</i>	Indirect	Public health
<i>Radiation Safety (General) Regulations 1983</i>	Indirect	Radiation safety
<i>Radiation Safety (Qualifications) Regulations 1980</i>	Indirect	Radiation safety
<i>Radiation Safety Act 1975</i>	Indirect	Radiation safety
<i>Voluntary Assisted Dying Act 2019</i>	Indirect	Voluntary assisted dying
<i>Work Health and Safety (General) Regulations 2022</i>	Indirect	Workplace health and safety and compensation

Instrument	Regulation of Scope of Practice	Subject
<i>Work Health and Safety Act 2020</i>	Indirect	Workplace health and safety and compensation
<i>Workers' Compensation and Injury Management (Scales of Fees) Regulations 1998</i>	Indirect	Workplace health and safety and compensation
<i>Workers' Compensation and Injury Management Act 1981</i>	Indirect	Workplace health and safety and compensation
<i>Workers' Compensation and Injury Management Act 2023</i>	Indirect	Workplace health and safety and compensation
<i>Workers' Compensation and Injury Management Regulations 1982</i>	Indirect	Workplace health and safety and compensation

## Part 3 - Definition Analysis Drugs and Poisons

This section relates to the targeted mapping and analysis of state and territory drugs and poisons legislation, undertaken as per the methodology outlined in *Table 2* (Part 1 – Legislation and Regulation review detailed methodology). As indicated in this methodology overview, targeted mapping and analysis of state and territory drugs and poisons legislation was undertaken which sought to a) indicate areas of inconsistency and b) ascertain how references to the National Law may have a (practically) limiting impact on scope of practice. In this context, a ‘reference to the National Law’ has been understood not only as a direct reference to the National Law, but – more commonly – the use of terms in state and territory drugs and poisons legislation which are defined in the National Law.

This section provides an overview of the high-level analysis of how key terms are variously defined across jurisdictions. Differences in definitions of key terms (for both activities and professions) can have a significant impact on scope of practice between jurisdictions.

*Table 4* below provides an overview of this definition analysis for the following terms:

- (1) “Administer”
- (2) “Deal (with)”
- (3) “Dispense”
- (4) “(Registered) Health Practitioners”
- (5) “Supply”

This table should be used in conjunction with Part 4 – Drugs and Poisons Mapping to interpret the findings of the ‘Drugs and Poisons Mapping’ exercise.

Table 4 Drugs and Poisons Mapping - Definitional Analysis

#### Definitions - analysis of selected key terms

This offers high-level analysis of how key terms are variously defined across jurisdictions. Differences in definitions of key terms (activities, professions etc.) can have significant impact on scope of practice between jurisdictions.

<b>Key:</b>	Not applicable to the jurisdiction	Included	Not included (where provision referenced, expressly excluded)	Requires further consideration (matter for statutory interpretation)
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	CTH	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
<b>"ADMINISTER"</b>				<i>Medicines, Poisons and Therapeutic Goods Act 2012</i>	<i>Medicines and Poisons Act 2019</i>				
Includes...				s 22(2)	"a dose": s 26(1)(a)				
Introduce into the body of a person					"a dose": s 26(1)(b)				
Give to a person to be taken immediately				"Scheduled substance".	A "medicine".				
Reference to specific substance									
<b>"DEAL [WITH]"</b>		<i>Medicines, Poisons and Therapeutic Goods Act 2008</i>		<i>Medicines, Poisons and Therapeutic Goods Act 2012</i>	<i>Medicines and Poisons Act 2019</i>				
Includes...		s 19(1)(c)		s 17(d)	s 18(c)				
Possess substance		s 19(1)(d)		s 17(e)	s 18(d)				
Supply substance		s 19(1)(e)		s 17(f)					
Administer substance					s 18(e)(i)				
Administer medicine				s 17(b)					
Prescribe substance		s 19(1)(h)(i)			s 18(e)(ii)				
Prescribe medicine		"prescribe"		"issue a prescription"	"prescribe"				
Notes									



	CTH	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
<b>"DISPENSE"</b>		<i>Medicines, Poisons and Therapeutic Goods Act 2008</i>			<i>Medicines and Poisons Act 2019</i>	<i>Controlled Substances (Poisons) Regulations 2011</i>			<i>Medicines and Poisons Regulation 2016</i>
Includes...									
Supply on prescription		Dictionary				s 3(1)			reg 3
Sell on prescription		s 24(a)(i)			s 25(2)	Act, s 4(1)			Act, s 8(1)
Reference to specific substance		Substance not specified.			A "medicine" is dispensed.	A "drug" is dispensed.			Substance not specified.

<b>"(REGISTERED) HEALTH PRACTITIONER"</b>	<i>Therapeutic Goods Act 1989,</i>	<i>Health Practitioner Regulation National Law (ACT)</i>	<i>Health Practitioner Regulation National Law (NSW)</i>	<i>Health Practitioner Regulation National Law (NT)</i>	<i>Health Practitioner Regulation National Law (QLD)</i>	<i>Health Practitioner Regulation National Law (SA)</i>	<i>Poisons Regulation 2018</i>	<i>Health Practitioner Regulation National Law (VIC)</i>	<i>Health Practitioner Regulation National Law (WA)</i>
Includes...									
Medical	s 3(c)	s 5(e)	s 5(e)	s 5(e)	s 5(e)	s 5(e)	s 3(1)(b)	s 5(e)	s 5(e)
Nursing	s 3(e)	s 5(ga)	s 5(ga)	s 5(ga)	s 5(ga)	s 5(ga)	s 3(1)(d), (f)	s 5(ga)	s 5(ga)
Midwifery	s 3(f)	s 5(g)	s 5(g)	s 5(g)	s 5(g)	s 5(g)	s 3(1)(e)	s 5(g)	s 5(g)
Pharmacy	s 3(i)	s 5(k)	s 5(k)	s 5(k)	s 5(k)	s 5(k)	s 3(1)(c)	s 5(k)	s 5(k)
Paramedicine		s 5(ja)	s 5(ja)	s 5(ja)	s 5(ja)	s 5(ja)		s 5(ja)	s 5(ja)
Physiotherapy	s 3(j)	s 5(l)	s 5(l)	s 5(l)	s 5(l)	s 5(l)		s 5(l)	s 5(l)
Podiatry	s 3(k)	s 5(m)	s 5(m)	s 5(m)	s 5(m)	s 5(m)	s 3(1)(h)	s 5(m)	s 5(m)
<b>Relevant definition in each jurisdiction:</b>	"health practitioner"	"health practitioner"	"health practitioner"	"health practitioner"	"health practitioner"	"registered health practitioner"	"health practitioner"	"registered health practitioner"	"registered health practitioner"

CTH	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
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"SUPPLY"	<i>Therapeutic Goods Act 1989</i>	<i>Medicines, Poisons and Therapeutic Goods Act 2008</i>	<i>Poisons and Therapeutic Goods Act 1966</i>	<i>Medicines, Poisons and Therapeutic Goods Act 2012</i>	<i>Medicines and Poisons Act 2019</i>	<i>Controlled Substances Act 1984</i>	<i>Poisons Act 1971</i>	<i>Drugs, Poisons and Controlled Substances Act 1981</i>	<i>Medicines and Poisons Act 2016</i>
Includes...									
Administer	s 3(d)	s 24(b)			s 24(2)		s 3(1)(a)		s 8(1)
Dispense		s 24(a)(ii)*	s 4(a)	s 21(1)(b)			s 3(1)(b)		Regulations, reg 37
Sell	s 3(a)	s 24(a)(i)	s 4(a)	s 21(1)(a)	s 24(1)	s 4(1)	s 3(1)(c)	s 4(1)(a)	s 8(1)
Prescribe			s 4(g)**						
Other	s 3(b)-(c)	s 24(a)(iii)-(iv)	s 4(c)-(f)			s 4(1)		s 4(1)(b)-(c)	s 8(2)

\* Except for the purposes of Chapter 10.

\*\* In NSW, a person may "authorise" or "direct" the dispensing and selling of medicines under the Poisons and Therapeutic Goods Act 1966 (NSW).

## Part 4 – Drugs and Poisons Mapping

The purpose of this section is to present a summary of the detailed mapping all state and territory drugs and poisons legislation, which was undertaken to identify areas of inconsistency between states and territories and to ascertain how references to the National Law may have a (practically) limiting impact on scope of practice.

The review involved mapping the following domains of competency (ways of dealing with medicines) in each state and territory in Australia:

- 1) Supplying;
- 2) Prescribing;
- 3) Possessing; and
- 4) Administering.

The tables below provide a summary of the detailed mapping exercise. Each table sets out mapping in respect of one domain of competency, identifying the activities which make up that domain, and mapping whether each in-scope health practitioner has statutory authorisation to perform that activity or domain in each state or territory. The mapping details which schedule of medicines is relevant, and whether an endorsement or further authorisation is required in a particular jurisdiction.

Each table is supported by a key for how to read and interpret the table. Below each table is further information relevant to the context of each activity.

### General findings:

The detailed ‘Drugs and Poisons Mapping’ as part of this Legislation and Regulation Review demonstrates that whilst each jurisdiction in Australia has largely adopted the Drugs and Poisons legislation with similar intention, the differences between which primary health care practitioners are authorised to do the activities, under which circumstances, can vary largely between each jurisdiction.

The difference in the adoption of the Drugs and Poisons legislation between the states and territories is also evident in the variation in terminology used in each jurisdiction (see Part 3 - Definition Analysis Drugs and Poisons for further detail). For the purposes of this Appendix, the professions have been mapped with reference to those relevant to this Issues Paper. However, noting the variation in references to who can carry out activities in legislation, the interpretation required to draw these conclusions and consolidate the professions into just those which are relevant is considerable.

Further insights from this Drugs and Poisons Mapping exercise are explored in the body of this Issues Paper.

## Table 5: Supplying

The purpose of mapping drugs and poisons legislation for this Review was to identify how primary health practitioners are enabled (or hindered) from participating in four different domains of competency in respect of drugs and poisons in each state and territory. The relevant domain of competency for this table is:

### supplying a scheduled / regulated substance (i.e. a medicine).

This table below sets out high level findings from detailed mapping, including:

- (A) the relevant tasks included under 'supplying a scheduled / regulated substance';
- (B) whether the relevant health practitioner(s) have statutory authority to perform within a domain of competency;
- (C) if there is statutory authority, which substances (by Schedule) are captured.

#### Key:



**[A]** The numbers above refer to the relevant Schedule of the same number under the Commonwealth Poisons Standard, as adopted in each state and territory. For example, '2' represents 'Schedule 2 - Pharmacy Medicines' under the Poisons Standard, as applied in the relevant jurisdiction.

**[B]** Where a number is coloured **'blue'**, this demonstrates that the relevant health practitioner requires an endorsement or other statutory authorisation to 'supply' the drugs listed under the schedule.

**[C]** Where a cell is blocked out in **'dark grey'**, this demonstrates that the task is not applicable to the health professional within the identified jurisdiction.

**[D]** Where a cell is blocked out **'orange'**, this indicates that whilst the term is used in the legislation, the task is not included within the meaning of 'supply' in that jurisdiction.

**[E]** Where a cell is blocked out **'green'**, this indicates that the task is included in the definition of supply. For example, 'supply' in Tasmania includes 'dispense' and 'administer'.

**[F]** Where the cell is blocked out **'red'**, this indicates that the task is not included, where the provision references, expressly excluded.

**\*** Means there are further conditions, other than endorsement, that restrict the supply of drugs and poisons under the Schedule.

Task	Profession	Enabled by legislative authority							
		ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Supply	Medical practitioner	2 3 4 8	4 8	4 8		2 3 4	2 3 4 8	2 * 3 * 4 * 8 *	2 3 4 8
	Midwife	2 3 4 8	1 2 3 4 8 8	3 4 2 8		2 3 4	4 8	2 3 4 8	2 3 4 8
	Nurse	2 3 4 8	1 2 3 4 8 8 *	3 4 2 8		2 3 4	4 * 8	2 3 4 8	2 3 4 8
	Nurse Practitioner	2 3 4 8	1 2 3 4 8	4 8		2 3 4	2 3 4 8	2 3 4 8	2 3 4 8
	Paramedic	2 3 4 8	8 *	3 4 2 8		2 3 4	8		2 3 4 8
	Pharmacist	2 * 3 * 4 * 8 *	3 * 4 8	3 4 2 8	2 3 4 8	2 3 4	2 3 4 8	2 * 3 * 4 * 8 *	2 3 4 8
	Podiatrist	2 3 4 8	1 2 3 4 8	4 8		2 3 4	2 3 4 8	2 3 4 8	2 * 3 * 4 * 8 *
Administer	Medical practitioner								
	Midwife								
	Nurse								
	Nurse Practitioner								
	Paramedic								
	Pharmacist								
	Podiatrist								
Dispense*	Medical practitioner				2 3 4 8				
	Midwife								
	Nurse								
	Nurse Practitioner								

	Paramedic								
	Pharmacist	2 3 4 8	8		2 3 4 8				4 8
	Podiatrist								
Sell	Medical practitioner					4	2 3 4 8		
	Midwife					4	4 8		
	Nurse					4	8		
	Nurse Practitioner					4	2 3 4 8		
	Paramedic					4	8		
	Pharmacist				2 3 4	4 *	2 3 8		
	Podiatrist					4	2 3 4 8		
Other**	Medical practitioner	2 3 4 8			2 3 4 8				
	Midwife	2 3 4 8			2 * 3 * 4 * 8 *				
	Nurse	2 3 4 8			2 3 4 8				
	Nurse Practitioner	2 3 4 8			2 3 4 8				
	Paramedic	2 3 4 8							
	Pharmacist	2 3 4 8			2 * 3 * 4 * 8 *				
	Podiatrist	2 3 4 8			2 3 4 8				

\* See Part 3 - Definition Analysis Drugs and Poisons for the definition of 'dispense' in each jurisdiction.

\*\* Other includes the following activities, aligned to the relevant jurisdictions:

[1] ACT – 'Deal'.

[2] NSW – see section 4 (c)-(f) Poisons and Therapeutic Goods Act 1966.

[3] NT – Not relevant.

[4] QLD – 'Give a treatment dose'.

[5] SA – see section 4 (1) Controlled Substances Act 1984.

[6] TAS – Not relevant.

[7] VIC – 'Apply for a license' (The business of the person applying for a licence must be at least 25 km from the nearest pharmacy: Drugs, Poisons and Controlled Substances Regulations 2017 (Vic), reg 157).

[8] WA – See section 8(2) of Medicines and Poisons Act 2016.

**For note:**

1. Whilst 'a person' is not noted as a profession in [Table 5](#), the Drugs and Poisons mapping exercise demonstrated that in various jurisdictions, 'a person' may be authorised to 'supply' medicines under specific circumstances, commonly following authorisation and licensing from a relevant Minister or Secretary.
2. For consideration when interpreting the Northern Territory jurisdiction: whilst not noted explicitly under the profession column, various provisions appear, in being limited to 'NT' health practitioners in the legislation and regulation, to prevent a health practitioner from another jurisdiction being authorised in the NT to partake in certain activities for different scheduled substances. This requires further consideration / statutory interpretation.



## Table 6: Prescribing

The purpose of mapping drugs and poisons legislation for this Review was to identify how primary health practitioners are enabled (or hindered) from participating in four different domains of competency in respect of drugs and poisons in each state and territory. The relevant domain of competency for this table is:

**prescribing a scheduled / regulated substance (i.e. a medicine).**

This table below sets out high level findings from detailed mapping, including:

- (A) the relevant tasks included under 'prescribing a scheduled / regulated substance';
- (B) whether the relevant health practitioner(s) have statutory authority to perform within a domain of competency;
- (C) if there is statutory authority, which substances (by Schedule) are captured.

**Key:**



**[A]** The numbers above refer to the relevant Schedule of the same number under the Commonwealth Poisons Standard, as adopted in each state and territory. For example, '2' represents 'Schedule 2 - Pharmacy Medicines' under the Poisons Standard, as applied in the relevant jurisdiction.

**[B]** Where a number is highlighted in '**blue**', this demonstrates that the relevant health practitioner requires an endorsement or other statutory authorisation to 'prescribe' the drugs listed under the schedule.

**[C]** Where a cell is blocked out in '**dark grey**', this demonstrates that the task is not applicable to the health professional within the identified jurisdiction.

\* Means there are further conditions, other than endorsement, that restrict the 'prescribing' of drugs and poisons under the Schedule. For example, 'a nurse practitioner must not issue a prescription for a drug of addiction otherwise than in the course of practising as a nurse practitioner' *Poisons and Therapeutic Goods Regulation 2008 (NSW)*, reg 78(2).

Task	Profession	Enabled by legislative authority							
		ACT	NSW	NT	QLD	SA	TAS	VIC**	WA
Prescribe	Medical practitioner	2 3 4 8	8		2 * 3 * 4 * 8 *	4 8	2 3 4 8	8	4 8
	Midwife	2 * 3 * 4 * 8 *	1 2 3 4 8		1 2 3 4	4 8	2 * 3 * 4 * 8 *		4 8
	Nurse		1 2 3 4 8			4 8	2 3 4 8		
	Nurse Practitioner	2 3 4 8	1 * 2 * 3 * 4 * 8 *		2 3 4 8	4 8	2 3 4 8	8	4 8
	Paramedic					4 8			
	Pharmacist				4 *	4 8	2 3 4 8		
	Podiatrist		1 2 3 4		2 * 3 * 4 * 8 *	4 8	2 3 4 8		2 * 3 * 4 * 8 *
Issue a prescription	Medical practitioner		2 3 4 8 *	2 3 4 8			4 8	3 4 8	
	Midwife		2 3 4 8 *	2 3 4 8			4 8	3 4 8	
	Nurse		2 3 4 8	2 3			4 8		
	Nurse Practitioner		4 * 8 *	2 3 4 8			4 8	3 4 8	
	Paramedic			2 3					
	Pharmacist			2 3			4 8		

	Podiatrist		2 3 4 8	2 3 4 8			4 8	3 4	
Other*	Medical practitioner	8 *						4 8	2 * 3 * 4 * 8 *
	Midwife	8 *						4 8	2 * 3 * 4 * 8 *
	Nurse								
	Nurse Practitioner	8 *						4 8	2 * 3 * 4 * 8 *
	Paramedic								
	Pharmacist								
	Podiatrist							4 8	2 * 3 * 4 * 8 *

\* Other includes the following activities, aligned to the relevant jurisdictions:

[1] ACT – ‘apply for an approval to prescribe’ and ‘apply for an endorsement to prescribe’.

[2] VIC – ‘prescription’ and ‘issue verbal instructions to supply’.

[3] WA – ‘give a direction for supply’.

\*\* In Victoria, note section 14 of the Act which requires a health practitioner to comply with any limitations on dealing with medicines imposed by a relevant National Board.

#### For note:

1. Whilst ‘a person’ is not noted as a profession in [Table 6](#), the Drugs and Poisons mapping exercise demonstrated that in various jurisdictions, ‘a person’ may be authorised to ‘prescribe’ medicines under specific circumstances, commonly following authorisation and licensing from a relevant Minister or Secretary. For example, some provisions permit ‘a person’ who holds a substance authority to carry out ‘regulated’ activities with a ‘regulated’ substance, if licensed to do so by a Minister (*South Australia*).

2. For consideration when interpreting the Northern Territory jurisdiction: whilst not noted explicitly under the profession column, various provisions appear, in being limited to 'NT' health practitioners in the legislation and regulation, to prevent a health practitioner from another jurisdiction being authorised in the NT to partake in certain activities for different scheduled substances. This requires further consideration / statutory interpretation.

## Table 7: Possessing

The purpose of mapping drugs and poisons legislation for this Review was to identify how primary health practitioners are enabled (or hindered) from participating in four different domains of competency in respect of drugs and poisons in each state and territory. The relevant domain of competency for this table is:

**possessing a scheduled / regulated substance (i.e. a medicine).**

This mapping sets out extracts from relevant legislation including:

- (A) the relevant tasks included under 'possessing a scheduled / regulated substance';
- (B) whether the relevant health practitioner(s) have statutory authority to perform activities within a domain of competency;
- (C) if there is statutory authority, which substances (by Schedule) are captured.

**Key:**



**[A]** The numbers above refer to the relevant Schedule of the same number under the Commonwealth Poisons Standard, as adopted in each state and territory. For example, '2' represents 'Schedule 2 - Pharmacy Medicines' under the Poisons Standard, as applied in the relevant jurisdiction.

**[B]** Where a number is highlighted in **'blue'**, this demonstrates that the relevant health practitioner requires an endorsement or other statutory authorisation to 'possess' the drugs listed under the schedule.

**[C]** Where a cell is blocked out in **'dark grey'**, this demonstrates that the task is not applicable to the health professional within the identified jurisdiction.

\* Means there are further conditions, other than endorsement, that restrict the possess of drugs and poisons under the Schedule.

Task	Profession	Enabled by legislative authority							
		ACT**	NSW	NT	QLD	SA***	TAS	VIC	WA
Possess	Medical practitioner	2 3 4 8	8	3 * 4 8 *	4 8	4 *	4 * 8	2 * 3 * 4 * 8 *	4 8
	Midwife	2 3 4 8	1 2 3 4 8	4 8	4 8	4 *	4 * 8 *	2 * 3 * 4 * 8 *	4 8
	Nurse	2 3 4 8	1 2 3 4 8	4 8	4 8	4 *	4 * 8 *	2 * 3 * 4 * 8 *	4 8
	Nurse Practitioner	2 3 4 8	1 2 3 4 8	3 * 4 8 *	4 8	4 *	2 * 3 * 4 * 8 *	2 * 3 * 4 * 8 *	4 8
	Paramedic <small>*[ambulance officer] not defined under ACT, NSW, SA act or regulations. Possible that it includes paramedic.</small>	2 3 4 8	2 * 3 * 4 * 8 *	4 8		4 *	4 * 8		4 8
	Pharmacist	2 3 4 8	8 *	4 8	4 8	4 *	4 * 8	2 * 3 * 4 * 8 *	4 8
	Podiatrist	4 * 8 *	1 2 3 4	4 8	4 8	4 *	4 * 8	2 * 3 * 4 * 8 *	2 * 3 * 4 8 *
Deal*	Medical practitioner	2 3 4 8							
	Midwife	2 3 4 8							
	Nurse	2 3 4 8							
	Nurse Practitioner	2 3 4 8							
	Paramedic	2 3 4 8							
	Pharmacist	2 3 4 8							
	Podiatrist	2 3 4 8							

\* See Part 3 - Definition Analysis Drugs and Poisons for the definition of 'deal' in each jurisdiction.

\*\* Note for ACT – there is a general condition placed upon the professions to 'possess' within the scope of their employment.

\*\*\* Note for South Australia - *health practitioners are authorised to 'possess' for the purpose of 'supplying'.* See the 'Supply' table for further details.

**For note:**

1. Whilst 'a person' is not noted as a profession in [Table 7](#), the Drugs and Poisons mapping exercise demonstrated that in various jurisdictions, 'a person' may be authorised to 'possess' medicines under specific circumstances, commonly following authorisation and licensing from a relevant Minister or Secretary.
2. For consideration when interpreting the Northern Territory jurisdiction: whilst not noted explicitly under the profession column, various provisions appear, in being limited to 'NT' health practitioners in the legislation and regulation, to prevent a health practitioner from another jurisdiction being authorised in the NT to partake in certain activities for different scheduled substances. This requires further consideration / statutory interpretation.



## Table 8: Administering

The purpose of mapping drugs and poisons legislation for this Review was to identify how primary health practitioners are enabled (or hindered) from participating in four different domains of competency in respect of drugs and poisons in each state and territory. The relevant domain of competency for this table is:

**administering a scheduled / regulated substance (i.e. a medicine).**

This mapping sets out extracts from relevant legislation including:

- (A) the relevant tasks included under 'administering a scheduled / regulated substance';
- (B) whether the relevant health practitioner(s) have statutory authority to perform activities within a domain of competency;
- (C) if there is statutory authority, which substances (by Schedule) are captured.

**Key:**



**[A]** The numbers above refer to the relevant Schedule of the same number under the Commonwealth Poisons Standard, as adopted in each state and territory. For example, '2' represents 'Schedule 2 - Pharmacy Medicines' under the Poisons Standard, as applied in the relevant jurisdiction.

**[B]** Where a number is highlighted in **'blue'**, this demonstrates that the relevant health practitioner requires an endorsement or other statutory authorisation to 'administer' the drugs listed under the schedule.

**[C]** Where a cell is blocked out in **'dark grey'**, this demonstrates that the task is not applicable to the health professional within the identified jurisdiction.

**[D]** Where a cell is blocked out **'green'**, this indicates that the task is included in the definition of supply. For example, 'supply' in Tasmania includes 'dispense' and 'administer'.

\* Means there are further conditions, other than endorsement, that restrict the 'administration' of drugs and poisons under the Schedule.

Task: Administer								
Profession	Enabled by legislative authority							
	ACT*	NSW**	NT	QLD***	SA	TAS****	VIC	WA
Medical practitioner	2 3 4 8	4 * 8 *	2 3 4 8	2 3 4 * 8 *	4 8 *	See 'Supply' table	3 4 * 8 *	4 8
Midwife	2 3 4 8 2 * 3 * 4 * 8 *	4 * 8 *	2 3 4 * 8 *	2 3 4 * 8 *	4	2 * 3 * 4 4 *	2 * 3 * 4 * 8 *	4 8
Nurse	2 * 3 * 4 * 8 *	1 * 2 * 3 * 4 * 8 *	2 3 4 * 8 *	2 3 4 * 8 *	4	2 * 3 * 4 *	2 * 3 * 4 * 8 *	4 8
Nurse Practitioner	2 3 4 8	1 * 2 * 3 * 4 * 8 *	2 3 4 8	2 * 3 * 4 * 8 *	4	See 'Supply' table	3 4 * 8 *	4 8
Paramedic <small>*[ambulance officer] not defined under ACT act or regulations. Possible that it includes paramedic.</small>	2 3 4 8	4 * 8 *	2 3 4 * 8 *		4 *	4 *		4 8
Pharmacist	2 3 4 8	3 * 4 *	2 3 4 * 8 *	2 * 3 * 4 * 8 *	4 *	4 *	3 * 4 * 8 *	4 8
Podiatrist	3 4 8 *	4 * 8 *	2 3 4 8	2 * 3 * 4 * 8 *	4	3 * 4 *	3 * 4 *	2 * 3 * 4 8

\* In the ACT, section 20 of Medicines, Poisons and Therapeutic Goods Act 2008 defines what it means to be "authorised" to deal with a medicine (see also Part 3 - Definition Analysis Drugs and Poisons). If a self-regulated professional (e.g. dietician) were to hold a relevant licence, or were authorised by the Chief Health Officer under a regulation or otherwise authorised under a regulation to possess medicines, the self-regulated professional would not be in contravention of the ACT Act.

\*\* In NSW, to 'administer' requires a relevant authorisation and is limited to place of employment. Unlike other jurisdictions, in NSW there appears to be no provision to expressly allow health practitioners to 'administer' within the identified scope of this review.

\*\*\* In Queensland, the definition of "administer" includes "give a treatment dose". See the "Supply" table for more detail on "give a treatment dose".

\*\*\*\* In Tasmania, "supply" includes "dispense" and "administer". Section 47A of the *Poisons Act 1971 (the Tas Act)* provides that the regulations can allow for Schedule 2, Schedule 3, Schedule 4 and Schedule 8 medicines to be administered by such persons and in such circumstances as the regulations prescribe (notwithstanding section 26(1)). See the "Supply" table for more.

**For note:**

1. For consideration when interpreting the Northern Territory jurisdiction: whilst not noted explicitly under the profession column, various provisions appear, in being limited to 'NT' health practitioners in the legislation and regulation, to prevent a health practitioner from another jurisdiction being authorised in the NT to partake in certain activities for different scheduled substances. This requires further consideration / statutory interpretation.
2. In the Northern Territory, there are further provisions which may enable the supply, administer and possession of medicines in an 'emergency authorisation', which may impact scope of practice for primary health care professions in those cases. See provision Chapter 2, Part 2.3, Division 1 (78) in *Medicines, Poisons and Therapeutic Goods Act 2012*.

