Unleashing the Potential of our Health Workforce

Scope of Practice Review

Final Report

October 2024

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Acknowledgement of Country

The Scope of Practice Review team acknowledges the Traditional Owners of Country throughout Australia.

We pay our respects to their ancestors and their descendants, who continue cultural and spiritual connections to Country.

We recognise their contributions to Australian and global society.

Glossary

Aboriginal and Torres Strait Islander Health Workforce	For the purposes of this document, the Aboriginal and Torres Strait Islander Health Workforce refers to a broad range of health care providers including Aboriginal and Torres Strait Islander Health Practitioners, Health Workers, Hospital Liaison Officers and those who provide other care and support roles.
Aboriginal Community Controlled Health Organisation	An organisation operated by local First Nations communities, and controlled through a locally elected board, to deliver comprehensive, holistic and culturally appropriate health care to their communities.
Accreditation	Refers to a formal process of approval for a program of study or training that ensures a person who successfully completes that program or training has 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.
Allied health	Governments and allied health peak bodies generally recognise allied health professions that meet the following criteria: a university qualification (AQF 7 level or higher) accredited by a recognised national accreditation body; a national professional organisation with clearly defined membership criteria; clear national entry-level competency standards and assessment processes; autonomy of practice; and a clearly defined scope of practice.
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. For example, care provided by multidisciplinary care teams.
Consumer	A person who has used, or may potentially use, health services or is a carer for a patient using health services.
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	An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.
Fee-for-service	The main payment model for primary care in Australia, in which health care providers are paid per episode of care delivered by a specified type of health professional.
General practice	For the purposes of accreditation, general practice means a practice or health service that provides comprehensive, patient-centred, whole-person and continuous care, and where services are predominantly of a general practice nature.

General practitioner	A registered specialist medical practitioner who is qualified and competent to provide general practice anywhere in Australia; has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities; and maintains professional competence in general practice.
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	A Ministerial Council comprising Health Ministers from each State and Territory Governments and the Australian Government which has oversight of the National Registration and Accreditation Scheme and the Health Practitioner Regulation National Law, provides leadership and facilitates joint decision making on health issues of national importance.
Health Service Accreditation	An evaluation process that involves assessment by qualified external reviewers to assess a health service organisation's compliance with safety and quality standards. Accreditation also focuses on continuous quality improvement strategies that promote safe and high-quality healthcare. Awarding accreditation to a health service organisation provides assurance to the community that the organisation meets expected patient safety and quality standards.
Multidisciplinary team	Multidisciplinary 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.
Non-registered health workforce	Health workers not regulated under the National Registration and Accreditation scheme, including: Self-regulated workforce (see below) Other non-registered health workforces, who are subject to legislation and regulation including laws that practice specific activities (e.g., use of medicines and therapeutic goods), health complaints laws, consumer protection laws, or codes such as the 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).
Para-professional workforce (referred also in this document as 'other non-registered workforces')	Includes health assistants, technicians, care workers, and peer support workers. These workforces comprise part of the non-registered workforce and are referred to in parts of this document as 'other non-registered workforces' (as distinct from the self-regulated workforce, see below).
Placement	In the context of education and training, the term 'placement' refers to supervised workplace-based training experiences.

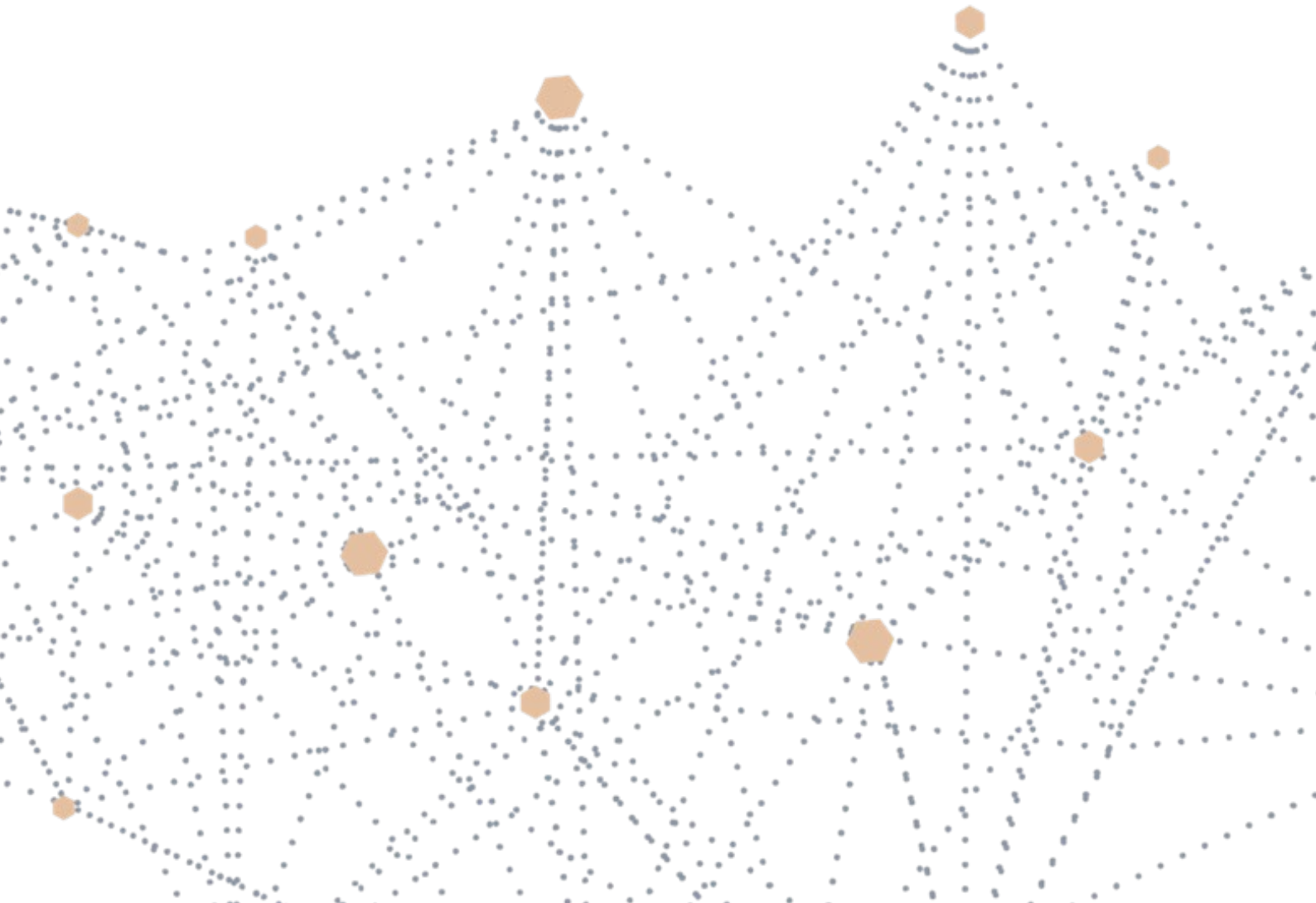
Practice standards, professional standards	Define the practice and behaviour of a health professional and may include codes of conduct, standards of practice, codes of ethics, as well as competency and professional capabilities.
Primary care	Primary care is a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care. It aims to optimise population health and reduce disparities across the population by ensuring that subgroups have equal access to services.
Primary health care	A whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities. It includes integrated health services to meet people's health needs across the life course; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health.
Professional capabilities	Professional capabilities identify the knowledge, skills and professional attributes needed to safely and competently practise as a health professional in Australia, i.e. the threshold level of professional capability required for both initial and continuing registration.
Registered professions; regulated professions	Professions regulated under the National Registration and Accreditation Scheme as per the Health Practitioner Regulation National Law that applies in each State and Territory.
Scope of practice (or full scope of practice)	Professional activities that a health professional is educated (skill and knowledge), competent and authorised to perform, and for which they are accountable. Individual scope is time-sensitive and dynamic. Scope of practice for individual health professionals 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.
Self-regulated professions	Professions regulated by profession-specific colleges and associations. Examples include speech pathology, social work, counsellors, exercise physiology and dietetics. These professions may also 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.
Universal health coverage	Means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

A word on terminology

Throughout this Review, we have aimed to use inclusive and respectful language and nationally accepted definitions, including those provided by the Department of Health and Aged Care, where available. We acknowledge that there are many different definitions for some of the included terms, and that some may disagree with the chosen definitions included in the Glossary.

We note that primary care rests on the contributions of many. For this reason, it is not practical to always include all health care providers or professions when describing the broad multidisciplinary primary care team. We acknowledge, for example, the many health professions who contribute to the allied health workforce and recognise that each contribute specific and significant expertise. Use of the term 'allied health' is not intended to in any way to diminish this unique professional expertise. Similarly, the Review has sought the views across the breadth of the primary care team and acknowledges the significant and increasing contribution of the assistant, support and technician workforces. It is hoped that the recommendations made in the Review will support and advance these important workforces.

The fundamental need for all health care, including primary care, to focus on the needs and preferences of the consumer cannot be overstated. Both the terms 'consumer' and 'patient' have been used throughout this document to indicate a person who has used or may potentially use health services (as defined in the Glossary). We also acknowledge the vital role of those in carer and support roles. The term 'patient' is commonly used in legislation and other references quoted throughout this report.



Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ACSQHC	Australian Commission on Safety and Quality in Health Care
Ahpra	Australian Health Practitioner Regulation Agency
CDMP	Chronic Disease Management Plan
CHF	Consumers Health Forum of Australia
CPD	Continuing Professional Development
GP	General Practitioner
HMM	Health Ministers' Meeting
IHACPA	Independent Health and Aged Care Pricing Authority
IPE	Interprofessional Education
LHN	Local Health Network
MBS	Medicare Benefits Schedule
MMM	Modified Monash Model
MPL	Multi-professional Learning
MSAC	Medical Services Advisory Committee
NASRHP	National Alliance of Self Regulating Health Professions
NHRA	National Health Reform Agreement
NRAS	National Registration and Accreditation Scheme
NRHA	National Rural Health Alliance
PBS	Pharmaceutical Benefits Scheme
PHI	Private Health Insurance
PHN	Primary Health Network
PII	Professional Indemnity Insurance
PIP	Practice Incentives Program
WIP	Workforce Incentive Program Practice Stream

Foreword

As Independent Reviewer, it is my great pleasure to introduce the Final Report from the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*, an ambitious program of work to reform our primary care workforce to deliver high-quality, equitable, integrated, and sustainable healthcare for Australian communities.

At the heart of this Review is a commitment to delivering high-quality primary care to consumers and communities. An appreciation of the vital role of the primary care workforce in the delivery of world class universal health care also underpins this Review. Together with consumers, our primary care health professionals and teams deliver comprehensive and holistic care to keep people healthy and well in the community, regardless of where they live and receive care.

This Independent Review, undertaken in response to recommendations from the *Strengthening Medicare* Taskforce Report, explores the system changes and practical improvements needed to support health professionals to work to their full scope of practice, optimising the use of resources across the primary care sector. Commencing in September 2023, the Review has considered the broader reform agenda at federal and state levels and evidence from national and international literature as well as the voices and perspectives of consumers and key stakeholder groups, including clinicians, governments, peak bodies, regulators, education and training providers, funders, insurers, professional bodies and unions.

This Final Report details a set of substantive reforms enabled by 18 recommendations, supported by implementation actions, to strengthen and modernise our primary care sector to meet current and future health needs, by building and supporting integrated and coordinated multidisciplinary care teams, removing barriers to enable health professionals to work to their full scope of practice and supporting leadership for organisational and cultural reform.

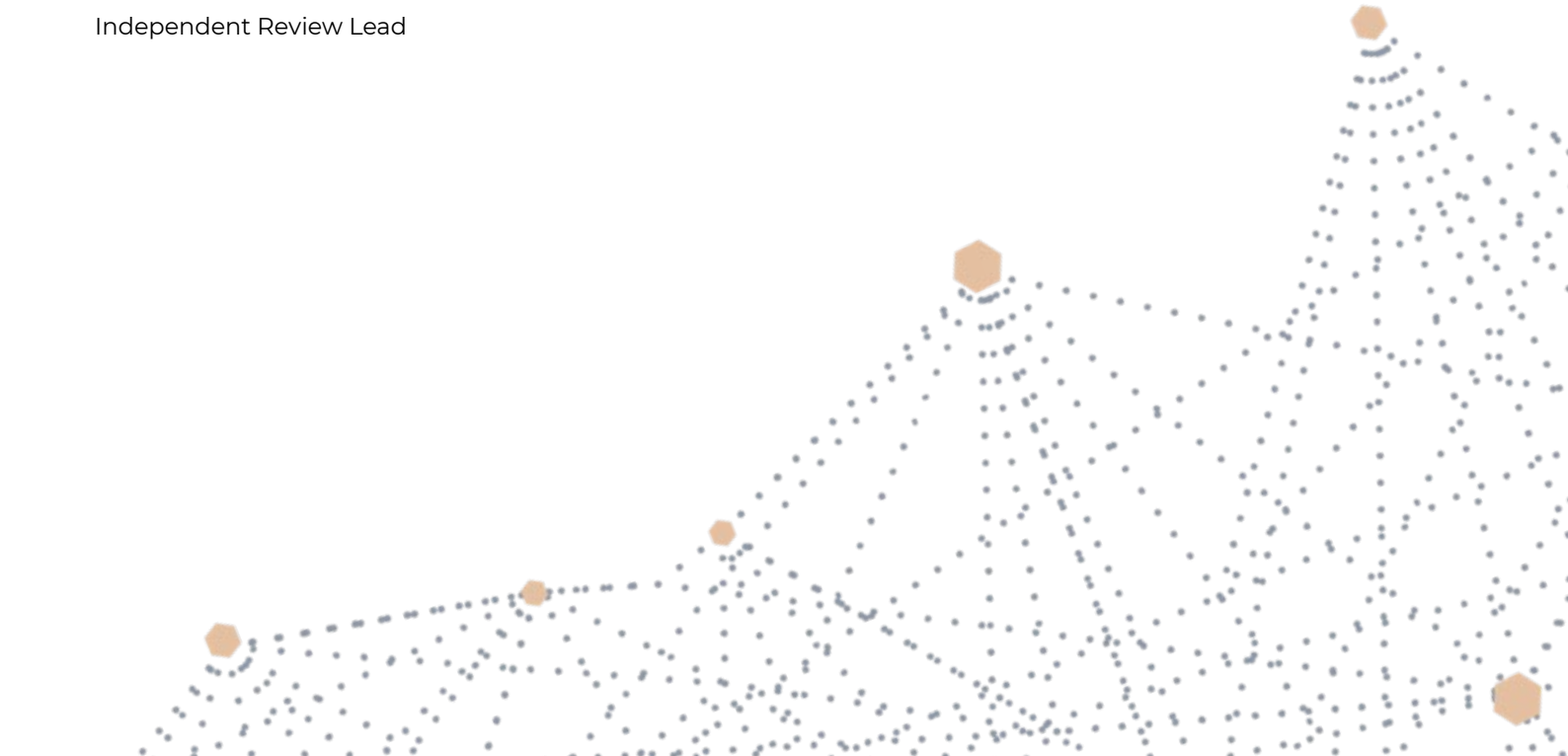
I am proud to have led this Independent Review and would like to take this opportunity to express my sincere gratitude to all those who contributed to the consultation sessions and provided valuable feedback, with special thanks to the Expert Advisory Committee convened to support this Review.

The Review has been enabled and supported by a highly skilled research team from the University of Queensland Centre for the Business and Economics of Health and KPMG who were integral to the research, consultation and drafting of the Report and Issues Papers. The Department of Health project team provided skilled project management support and the exemplary engagement across government needed for such a review.

I am confident that the insights from this Review and the recommendations outlined in this Final Report will provide us with the foundations and a pathway to success for workforce reform and a stronger, coordinated and integrated primary care sector.

Professor Mark Cormack

Independent Review Lead



Executive summary

Executive summary

Context

Australia has a strong commitment to achieving universal health coverage, meaning the delivery of a full range of health services that people are able to access when and where they are needed, without financial hardship. Primary care is a model of care that supports first-contact, accessible, comprehensive and coordinated care that helps meet people's health needs throughout the life course. It relies on access to a trusted group of health professionals who work together and contribute expertise to the delivery of health promotion, disease prevention, treatment, education, rehabilitation and support services for consumers.

Primary care services are provided by private businesses, not-for-profit organisations, community health clinics and Aboriginal Community Controlled Health Organisations (ACCHOs). A diverse range of health professionals deliver primary care, including members of the Aboriginal and Torres Strait Islander Health Workforce, general practitioners, nurses and nurse practitioners, midwives, paramedics, pharmacists, dentists and oral health therapists, and allied health professionals, as well as members of the technician, assistant and care workforces. Primary care health professionals contribute knowledge, skills and expertise to the delivery of care, developed through education, training and experience and work within a scope of practice. A health professional's scope of practice means the professional activities for which they are educated, competent, authorised and accountable.

Shortages in the health workforce are a persistent and global problem, impacting the availability and quality of care for consumers. Causes of workforce shortages include increased demand for healthcare from an ageing population and increased complexity of health needs, as well as limited supply due to an ageing workforce and barriers to education and training. These workforce shortages are more profound in rural and remote areas of Australia. Barriers to working to full scope of practice contribute to workforce shortages, as they prevent the most effective use of the existing workforce and potentially deter future recruits.

Being prevented from working to full scope of practice also contributes to some health professionals' decision to leave the health workforce, with rates of individuals leaving the profession higher amongst the professional categories who broadly experience the greatest barriers to working to their full scope of practice.

To maximise the sustainability of the primary care workforce and support the delivery of high-quality, equitable and efficient health care, the Australian Government has committed to an ambitious program of reform, aligned with previous primary care strategies and reviews, and recognising major challenges and shifts in the delivery of primary care. The *Strengthening Medicare Taskforce Report*, which commenced in 2022, provided priority recommendations to strengthen Medicare by increasing access to primary care, encouraging multidisciplinary team-based care, modernising primary care and supporting change management and cultural change. New initiatives arising from the Medicare Taskforce include MyMedicare, increases to bulk billing incentive payments, Medicare Urgent Care Clinics and this Independent Review of the barriers and enablers health practitioners face working to their full scope of practice in primary care.

Other current and ongoing health reform projects address the stability and sustainability of the health workforce. These include:

- Independent review of complexity in the National Regulation and Accreditation Scheme (NRAS)
- Independent review of health practitioner regulatory settings streamlining entry to practice for overseas trained health practitioners (the Kruk Review)
- Exploring the effectiveness of workforce distribution levers and improving consumer access to general practitioners (the Working Better for Medicare Review)
- Implementing accreditation reforms (independent review of accreditation systems within the NRAS, the Woods Review)
- Independent Review of General Practice Incentives
- Implementation of various national and State and Territory medical, nursing and allied health workforce plans.

While all are independent of each other, with different areas of focus, the findings and recommendations from the reviews and initiatives must be considered together to support system-level change and build an adaptable, flexible and responsive primary care system.

Objectives and Scope

This Independent Review is an ambitious program of work to understand the evidence related to health professional scope of practice in primary care, as well as the enablers and challenges to working to full scope and providing multidisciplinary team-based care. The policy parameters for this Review are the future directions in the *Strengthening Medicare Taskforce Report* focused on encouraging multidisciplinary team care through:

"Co-ordinated multidisciplinary teams of providers working to their full scope of practice provide person-centred continuity of care, including prevention and early intervention; and primary care is incentivised to work with other parts of the health system, with appropriate clinical governance, to reduce fragmentation and duplication, and deliver better health outcomes."[1]

While it is recognised that the multidisciplinary primary care workforce is broad and diverse, the health professionals who were considered for this Review include: general practitioners, nurses (including nurse practitioners, registered nurses and enrolled nurses), midwives, pharmacists, allied health professionals, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers and paramedics.

Methods

Evidence to inform this Review was collected through four phases that explored and progressively refined a comprehensive understanding of the specific issues that restrict primary care health professionals from working to their full scope of practice, the challenges that primary care teams face across a range of settings and the potential mechanisms to address these challenges.

Comprehensive stakeholder consultation was undertaken over the course of the Review with a diverse group of consumers, health professionals, governments, regulators, education and training providers, accreditation authorities, funders, insurers, professional associations and unions. Consultation informed the development of two issues papers and considered legislation and regulation; education and training; funding mechanisms; employer practices and work context; technology; and leadership and culture.

A literature and evidence review was completed to explore available evidence on the value of health professionals working to full scope of practice in primary care settings. International best practice case studies were identified to enable in-depth exploration of the impact of the political, social, health care and other contexts on scope of practice changes.

Given the importance of legislation and regulation in shaping and subsequently framing scope of practice, a legislation and regulation review was undertaken where these were identified as impacting practice scopes, either directly or indirectly. The objective of this Review was to identify barriers in the existing legislative environment to health professionals working to full scope of practice. The Review sought to identify a shortlist of legislative and regulatory matters considered which, if amended, would be likely to have the greatest positive impact on health professional scope of practice.

An Expert Advisory Committee (EAC) was also convened, comprised of representatives of the health workforce, education and training sector, universities and consumers. The EAC met for the first time in November 2023 and met in each Review Phase and contributed valued insights and expertise to inform the Review.

[1] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.

Findings

This Review identified a range of issues that impact the ability of all primary care health professionals to work to their full scope of practice. These issues are inextricably linked, and may influence, determine or maintain scope of practice over time. For the purposes of this Review, key issues have been grouped into the following three themes:

1. Workforce design, development, education and planning
2. Legislation and regulation
3. Funding and payment policy.

The Review found that **virtually all health professions in the primary care sector, including general practitioners, face some restrictions or barriers to working at full scope of practice that are unrelated to their education (skills and knowledge) and competence.** These barriers were noted to shape the primary care workforce and influence sustainability of the workforce over time, particularly in rural and remote locations. The sum of evidence pointed to key findings including:

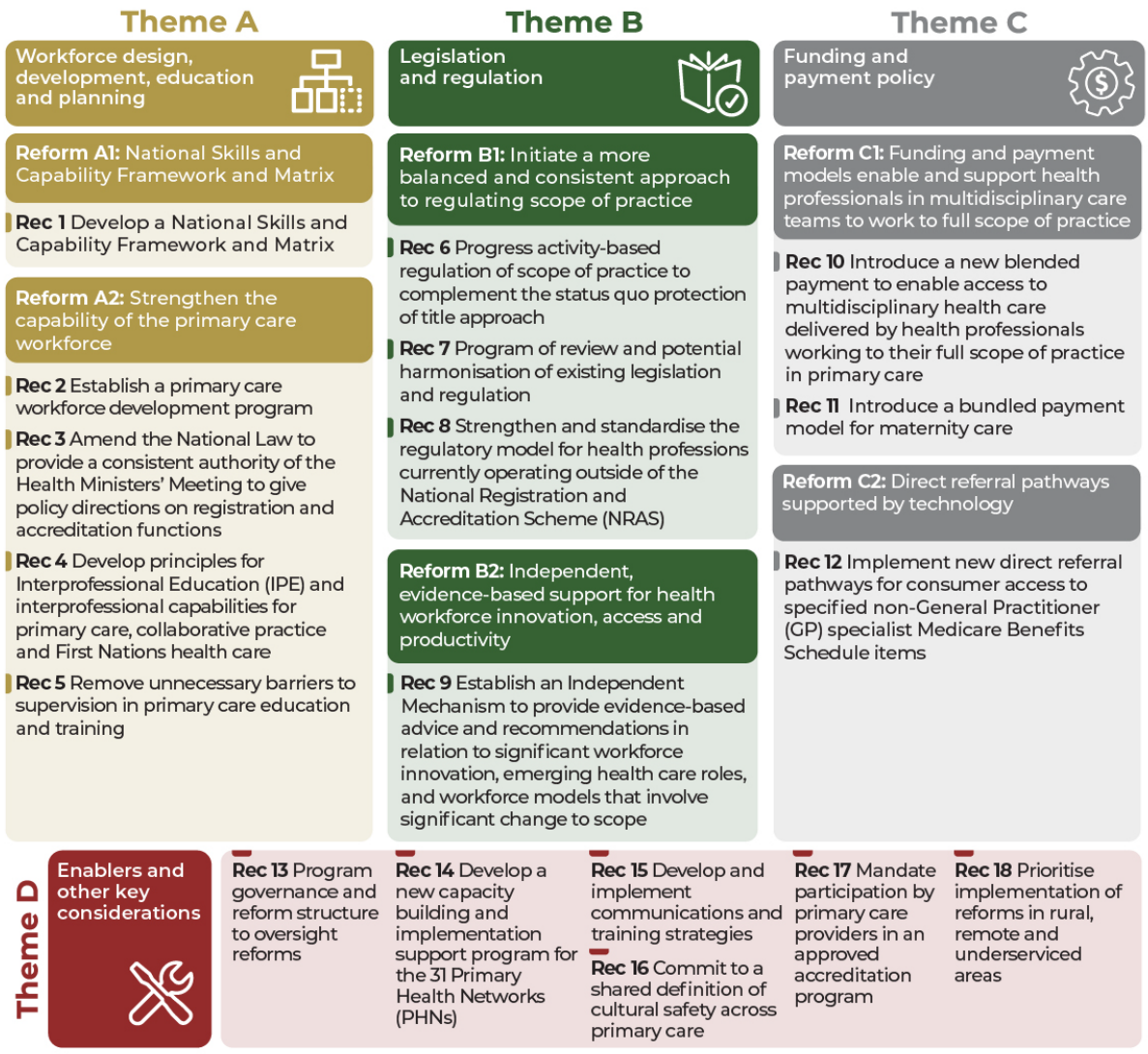
- **There is limited awareness of health professional scope of practice across the multidisciplinary primary care team**. Consumers and health professionals frequently have a limited understanding of the scope of practice (skills, knowledge, competence and authorisation) of members of the primary care team. This impedes clarity of roles, responsibility, accountability and interprofessional trust as well as the quality and accessibility of care for consumers.
- **Preparation of, and support for, health professionals to practise in primary care is limited, especially when compared to the public hospital and acute health care sector.** Learning about primary care during pre-professional entry programs is limited for some health professions, resulting in challenges in attracting the primary care workforce and impacting their preparedness to work in this setting. Support to maintain, and further develop, skills in primary care are limited, resulting in challenges in retaining the primary care workforce.
- **Support for health professionals to learn and work in multidisciplinary teams is limited.** Notwithstanding some exemplars in practice, most learning takes place in a mono professional manner, and this generally carries through to how primary care is delivered.
- **There are opportunities to improve health professional regulation.** The NRAS is a mature professional regulation scheme, which is well regarded and trusted by its participants and the system more broadly. Opportunities exist to strengthen and standardise regulatory approaches to address specific legislative and regulatory issues which materially impact scope of practice.
- **Other legislative and regulatory settings restrict scope of practice in primary care.** Outside the NRAS, other legislative and regulatory settings have a significant and restrictive impact on health professionals working to their full scope of practice. Drugs and poisons legislation, for example, can inconsistently impact scope of practice across locations. The legislative and regulatory environment should be more responsive to the pace and outcomes of health care innovations.
- **Funding and payment policy settings restrict scope of practice in primary care.** Funding and payment mechanisms impede health professionals from working to full scope of practice and as part of a multidisciplinary team. Health professionals practising and remunerated via a predominately fee-for-service payment system face the most significant barriers; those practising and remunerated in a non-fee-for-service payment system face the least barriers to working to full scope of practice and as part of a multidisciplinary team.
- **Structures, infrastructure and mechanisms to support and enable effective clinical governance and risk management in the primary care sector are variable,** more basic, less resourced and generally voluntary when compared to that which applies in the hospital sector.
- **Culture and leadership are the most critical dependencies for achieving change in primary care**. Healthcare reform requires cultural change at system, profession, organisation and individual levels.
- **Rural and remote settings** often provide the greatest opportunity for more immediate and enduring positive change which support full scope of practice in a multidisciplinary context, since these communities simultaneously represent the greatest need and greatest appetite for change, with a strong baseline of working in multidisciplinary care teams.
- **There are numerous examples of effective, team-based, full scope of practice models and services.** These include ACCHOs, rural and remote multidisciplinary services, community health services targeting higher risk, lower socioeconomic groups and innovative general practice models that employ, support and/or provide a range of multidisciplinary services and optimise the use of allied health professionals, primary health care nurses and pharmacists who work in general practice.

Recommendations

To address the challenges of working to full scope of practice and delivering multidisciplinary care within the primary care sector, a set of substantive reforms enabled by 18 recommendations are proposed, encompassing workforce design, development, education and planning; legislation and regulation; and funding and payment policy. Together, the recommendations provide a comprehensive and multifaceted approach to strengthen the primary care system and enable the delivery of high-quality, equitable, accessible and affordable care for Australian communities by a skilled, collaborative and sustainable workforce.

The combined recommendations are intended to remove the major barriers that impede health professionals from practising to their full scope, and that prevent multidisciplinary teams from providing the best collaborative care for consumers. Mechanisms that recognise the skills and capabilities of all primary care providers are included to enable the best available care to be provided by the most skilled member of the team and ultimately to deliver the best outcomes for consumers and communities.

Figure 1 Summary of reforms and recommendations



Workforce design, development, education and planning

Workforce reform is critical to equitably support all health professionals to have the opportunities and support needed to develop and maintain the high-level skills required to work to full scope of practice and contribute to comprehensive multidisciplinary care. The foundation of these recommendations is the development of a **National Skills and Capability Framework and Matrix** (Recommendation 1) to make the skills and capabilities of the primary care workforce explicit and transparent at a national level and remove incorrect or unfounded assumptions about health professional scope of practice. Additionally, a proposed **primary care workforce development program** (Recommendation 2) seeks to enhance the primary care-specific curriculum, training and career development for professions that work in primary care, supporting the development and retention of a skilled, stable and collaborative primary care workforce.

Recommendations 3 and 4 relate to improved national-level clarity regarding the scope of practice of health professionals as well as collaboration and consistency across the multidisciplinary primary care team. This is proposed to be enabled via **amendment to the National Law to provide a consistent authority for the Health Ministers' Meeting to give policy directions to the Australian Health Practitioner Regulation Agency (Ahpra) and National Boards on both accreditation and registration functions** (Recommendation 3). This reform would enable the Health Ministers' Meeting (HMM) to signal areas of high priority in support of the design and development of the primary care workforce. Additionally, the development of revised accreditation standards incorporating general principles for **interprofessional education, professional capabilities for primary care, collaborative practice and First Nations health care** will support this aim (Recommendation 4). It is expected that these principles will be reflected in Continuing Professional Development (CPD) content and relevant standards and guidelines applicable to CPD, enabling a strengthened focus on learning together as part of a cohesive primary care team.

The final proposed recommendation for workforce development relates to the **removal of unnecessary barriers to supervision in primary care education and training**, including those that restrict cross-professional supervision (Recommendation 5). A review of guidelines and accreditation standards that require, or suggest, exclusive profession-specific supervision is recommended, as well as a review of Medicare Benefits Schedule (MBS) rules and guidelines to support all health professions to provide practical workplace-based training in primary care. This Review is essential to ensure that all primary care health professionals are equitably supported to undertake clinical placement supervision.

Legislation and regulation

Legislation and regulation are critical to protecting the public by ensuring safe and ethical primary care practice. They were also identified as a barrier to health professionals working to full scope of practice in many circumstances. The proposed reform and harmonisation of legislation and regulation will create a system that is more consistent, balanced, adaptive and responsive. Primary care health professions will benefit from **activity-based regulation of scope of practice** to complement the current protection of title approach (Recommendation 6).

Additionally, a **targeted review and harmonisation of priority legislation and regulation**, commencing initially with the Drugs & Poisons Acts, Radiation Safety Acts and Mental Health Acts (Recommendation 7) will clarify and enable a wider range of health professionals to undertake restricted activities consistent with their scope of practice. In line with a more consistent and balanced approach to regulating scope of practice, it is recommended that the **regulatory model for professions operating outside of the NRAS is strengthened and standardised** (Recommendation 8) to address specific legislative and regulatory issues which most impact scope of practice among self-regulated professions, namely the pervasive use of shorthand references to the National Law in a range of legislation and regulation which indirectly regulate scope of practice.

The final proposed legislation and regulation recommendation relates to the establishment of an **Independent Mechanism** to provide evidence-based advice to government and key stakeholder groups in relation to emerging health care roles and workforce models that involve a significant change to scope of practice (Recommendation 9). It is expected that the Independent Mechanism will provide a more streamlined pathway into practice for new and innovative models of care and promote consistency across jurisdictions. It is also proposed that the Independent Mechanism will hold responsibility for the development and implementation of the National Skills and Capability Framework and Matrix.

Funding and payment policy

Funding and payment policy has a determinative impact on the sustainability and stability of the primary care workforce, as well as their ability to work to full scope of practice. The funding and payment policy recommendations proposed in this Review aim to promote a modern funding structure that is aligned to the breadth and diversity of care delivered in primary care settings, and which is more flexible, adaptive and supportive of consumers with complex health care needs.

The first funding and payment policy recommendation proposes the **introduction of a new blended payment to enable access to multidisciplinary health care** delivered by health professionals working to full scope of practice (Recommendation 10). The new payment would be supported by a growth in investment in primary care, shifting the ratio of Australian Government payments for primary care from 90:10 fee-for-service: blended payments to 60:40 over time (at an aggregate national level). This recommendation addresses and supports the growth of new and innovative primary care models, the sustainability of which have historically been limited due to challenges accessing MBS funding. The flexibility of primary care funding is further supported through the proposed introduction of a **bundled payment for maternity care** (Recommendation 11), which will enable consistency of funding for midwifery and shared care models, thereby providing women and families with a range of affordable, accessible and integrated maternity care options in primary care and hospital settings.

The final funding and payment recommendation relates to the implementation of **new direct referral pathways** for allied health professionals, midwives, nurse practitioners and remote area nurses to refer to non-GP medical specialists within their scope of practice, and with timely notification to GPs and relevant members of the multidisciplinary care team (Recommendation 12). This recommendation will remove the cost and delay in accessing care when consumers are required to obtain a referral from a GP to see a medical specialist. A relevant example is when a physiotherapist requests review by an orthopaedic surgeon in instances where conservative management has not been successful or where a patient presents with an acute or serious injury.

Enablers for change

Successful implementation of the recommendations proposed in this Review will require a series of enablers and key considerations. Broad **government and stakeholder commitment**, including through inclusion in the upcoming National Health Reform Agreement (NHRA), will be required to drive culture, leadership and implementation support across the primary care system (Recommendation 13). **Primary Health Networks (PHNs)** will hold a central role in supporting the reform agenda and will be given targeted capacity building and implementation support to complement existing planning, integration, practice support and commissioning functions (Recommendation 14).

To ensure the design and implementation of recommendations is appropriate, fit-for-purpose and sustainable, **communications and training**, and **embedded consumer co-design and consultation** will be essential principles of the reform program (Recommendation 15). Meanwhile, efforts to progress a **system-wide shared definition of cultural safety** will recognise this as a critical, underpinning principle for all primary care (Recommendation 16), building on existing efforts during the development of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 [2].

The proposed new requirement for participation in a relevant **accreditation program** (Recommendation 17), supported by a PHN-led capacity building program, will better support primary care providers to meet clinical governance and quality improvement requirements, and build trust and confidence across teams. Finally, a dedicated approach to prioritise implementation of reforms in **rural, remote and underserved communities** will apply to all relevant recommendations (Recommendation 18), acknowledging these are both the areas of greatest need and greatest immediate opportunity to establish and scale health workforce innovation and reform.

[2] Ahpra & National Boards (2023) Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Accessed 1 September 2024.

Achieving primary care reform

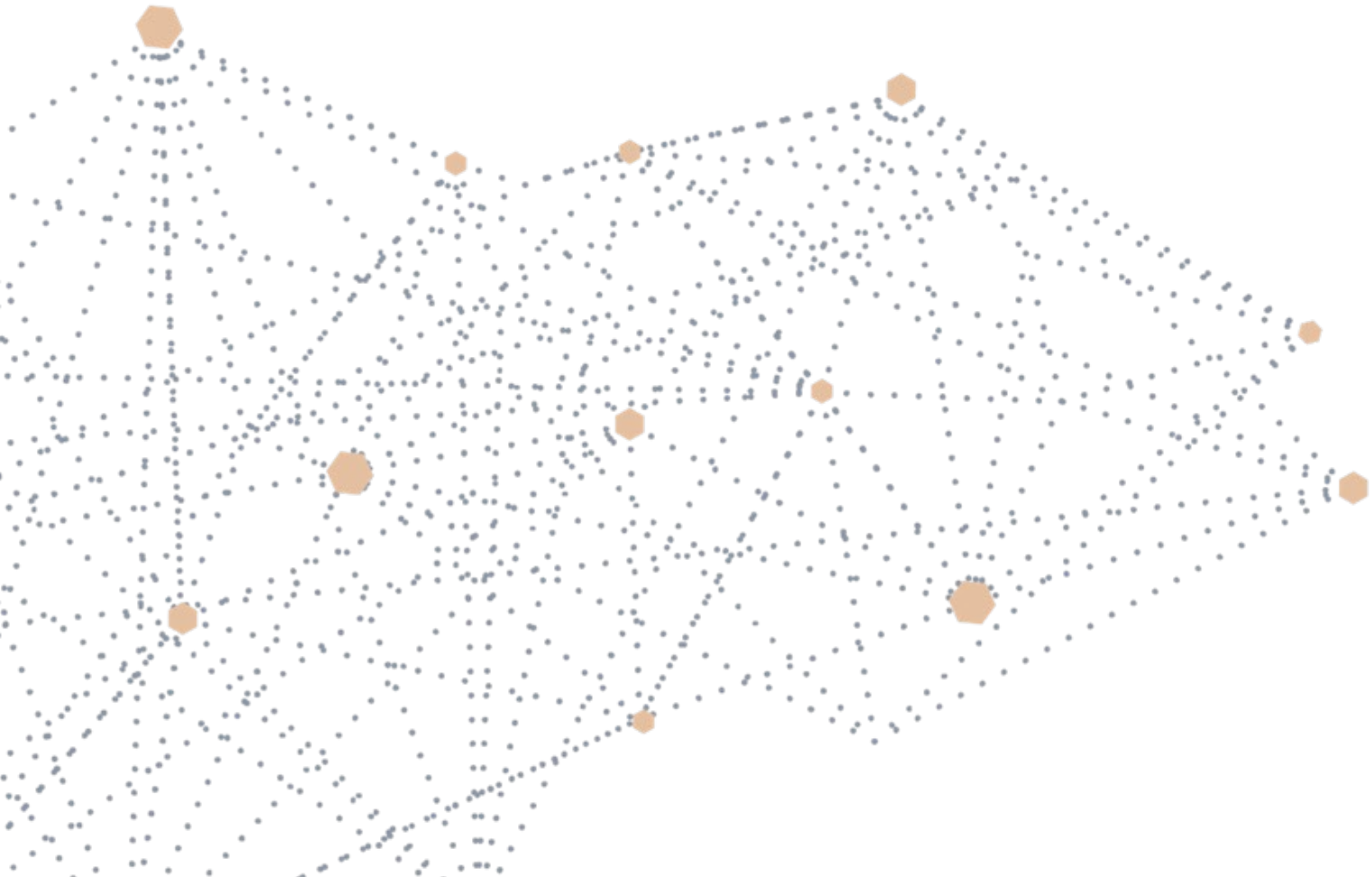
This Review acknowledges that health care reform is complex, challenging and requires time and system-level commitment. To make meaningful change, health policy will need to address the range of intersecting issues that impact scope of practice across workforce, legislation and regulation and funding policy areas. Implementing change across a single issue or for a few professions will not enable and support a more modern and integrated primary care system, as intended by the *Strengthening Medicare Taskforce Review*. Instead, cross-professional reform is required, respecting the professional skills, capabilities and expertise of all members of the primary care team. Although the proposed recommendations would be undertaken at a national level, it is recognised that successful change will require tailoring to the local context. This is particularly important for rural, remote, First Nations and underserved communities, who consistently experience workforce shortages and inequitable access to primary care.

Strong organisational leadership is well recognised as one of the most important factors supporting the implementation of significant workforce innovations. The reform agenda outlined in this Review will require shared commitment and accountability from leaders, as well as a culture where the workforce feels respected, valued and has permission to lead change.

Enabling full scope of practice requires clear expectations and accountabilities, supported by relevant policies and procedures. Regular monitoring, evaluation and research is also required to ensure optimal quality and safety and further build the evidence and practice base for optimising scope of practice within multidisciplinary team care.

Despite the challenges identified in this Review, there are numerous examples of effective and sustained multidisciplinary teams, primary care training and support programs, and models of care that support health professionals to work to their full scope of practice to provide person-centred continuity of care, including population health, prevention and early intervention services. The existence of such positive exemplars demonstrates the strength, commitment and unrealised potential of our health workforce.

This Review provides the foundation and a pathway to success for workforce reform and a stronger, coordinated and integrated primary care sector. With commitment and support from consumers, governments and key stakeholder groups, the implementation of this reform program will unleash the potential of our health workforce to support our world-class primary care system now and into the future.



Summary of recommendations

This section details the recommendations made by this Review and provides the reasons for the recommendations, how they could be implemented and the intended outcomes.

Develop a National Skills and Capability Framework and Matrix

Context

Limited information is available at a national level to describe the skills and capabilities of the primary care workforce. Where available, skill and capability descriptions provide information about individual professions but are not available in a format that reflects the entire primary care workforce.

Issues to be addressed

Poor understanding of the scope of practice and the proven skills and capabilities of health professionals prevents trust and cohesion within the healthcare team and impedes team function. Incomplete workforce data impedes workforce design, development, education and planning. These issues represent a barrier to the most effective use of the available workforce to meet community needs.

Recommendation 1

Health Ministers agree to the development of a National Skills and Capability Framework and Matrix (the Matrix) to support workforce design, development, education, and planning in primary care.

1.1 Establish an independent, national mechanism, reporting through to Health Ministers to create, maintain, develop and promote the Matrix. This may be incorporated as part of Recommendation 9.

1.2 Implement an ongoing program of education, promotion and adoption of the Matrix to support awareness of and adoption by consumers, the health workforce, employers and higher education providers, accreditors and funders.

1.3 National Boards and accreditation authorities regularly review the Matrix to align accreditation and registration functions relating to standards, codes, competencies and guidelines for nationally regulated health professions.

1.4 Professional bodies, in their capacity as self-regulating entities, regularly review the Matrix to align accreditation and professional standards functions relating to standards, codes, competencies and guidelines for self-regulated health professions.

Mechanism to achieve change

Developing the Matrix will require two steps:

- **Development of the Framework.** Establishment of shared language to describe the multidisciplinary primary care workforce and the sources of information used to construct the Matrix. Definition of the methods used to design, develop and maintain the Matrix, ensuring relevance and accuracy to primary care practice. Agreement on the initial capabilities to be included in the Matrix, noting that additional capabilities will be added.
- **Design and development of the Matrix.** Identification, collection and collation of verified data that describes the skills and capabilities of primary care professionals. Development of a consumer-friendly version of the Matrix. Formatting of all versions to ensure it is user friendly for all intended audiences.

The Matrix will initially describe a limited number of agreed capabilities that are common to primary care. For example, vaccination, which is provided by a range of health professionals and cultural safety which is required by all health professionals. Once established, additional capabilities will be added, with the possibility that the capabilities may extend across the continuum of health care, including hospital-based acute care.

Intended outcome of the recommendation

The Matrix will complement existing workforce initiatives and strategies. It will be used with comprehensive workforce data and modelling to inform policy decisions, including those focused on education and training, funding and payment, and legislation and regulation.

The Matrix will improve the visibility of health professionals' skills, capabilities and scope of practice, and enable identification of service gaps which can be addressed through mechanisms including transdisciplinary models of care and needs-based workforce planning.

For the consumer

Consumers will be better and more transparently informed of the skills and capabilities of the health professionals who provide their care.

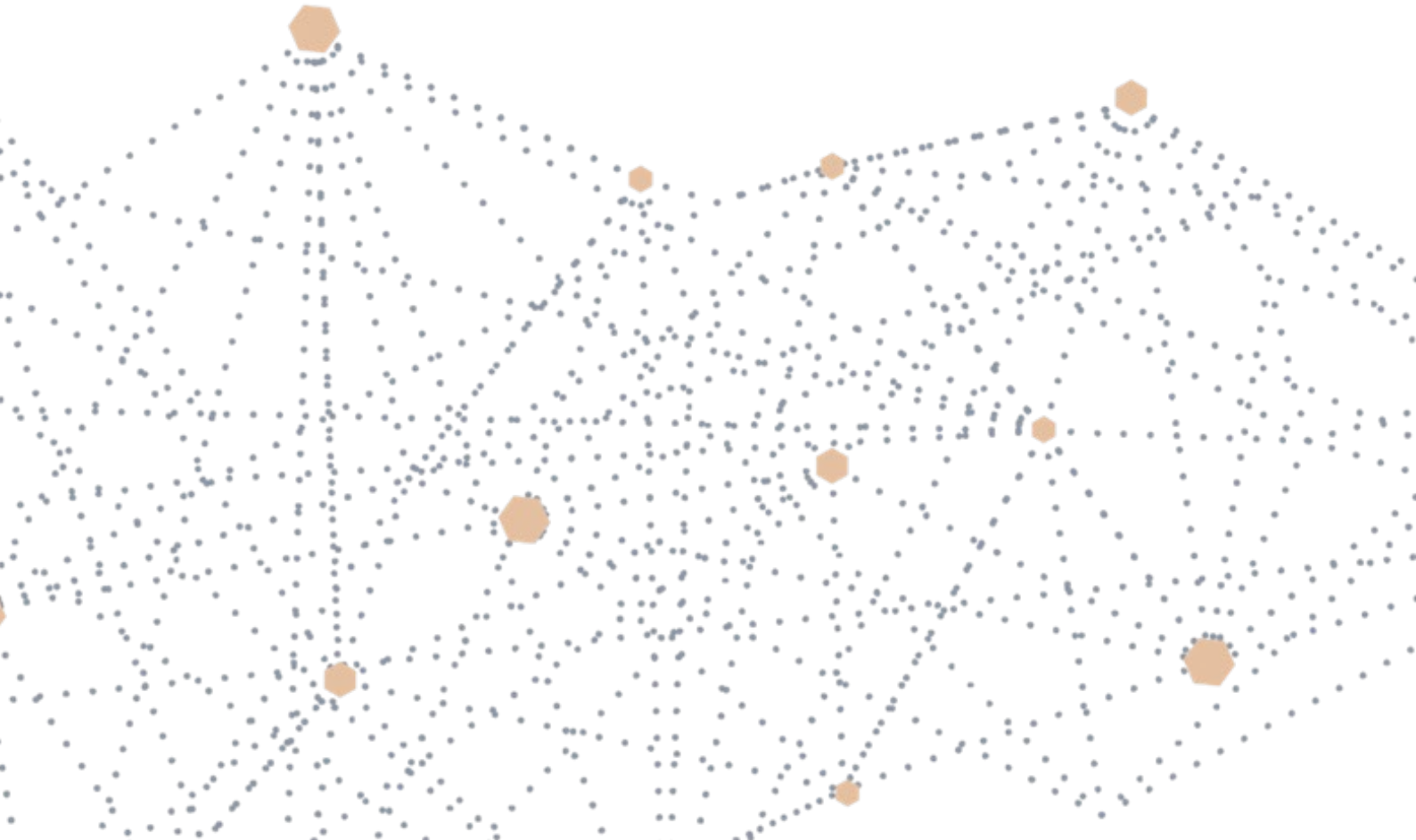
The Matrix will also inform health workforce design, planning, and development, enabling consumers to access timely care, provided as close to home as possible. This will be particularly useful for workforces in rural, remote and underserviced areas.

For the multidisciplinary team

Transparency in the skills and capabilities of members of the multidisciplinary team would contribute to team cohesiveness and an improved trust between team members. Workforce design, development and planning would benefit from more accurate data that describes the health workforce.

Gaps in service provision would be highlighted and emerging roles planned for.

- Education providers could use the Matrix to design curricula and identify areas for research, including innovative models of care to meet community need. Similarly, education providers would inform the Matrix of relevant curriculum change.
- Local authorisation processes across sectors and jurisdictions could be streamlined based on the Matrix, including a reduced need for health professionals to repeat credentialing requirements. This could facilitate greater workforce mobility



Establish a primary care workforce development program

Context

Quality education and training are vital to prepare the primary care workforce. Students need to understand primary care and how their scope of practice contributes to meeting the primary care needs of the communities they service. Supervised learning in the primary care setting is an important way for students to develop the skills and capabilities they need to practise in this setting. Students and health professionals need to develop and maintain the skills required to work effectively alongside other health professionals and other people who contribute to consumer care.

Developing the primary care workforce requires the following:

- Trained supervisors to support student learning.
- Opportunities for students to experience primary care in a range of contexts.
- Opportunities for health professionals to maintain their skills so they can provide the best care for consumers. This requires access to quality education and training and the time to complete the training they need. Where possible, health professionals should be able to learn together as a team to support the function of the care team.
- Health professional access to trained mentors or support from their colleagues to ensure they keep their skills and are professionally satisfied.

Issues to be addressed

The Review found there are a range of issues related to the way students learn and develop the skills required for the primary care setting which restrict their ability to work to full scope of practice. There are key opportunities to strengthen both the student (pre-professional entry) and qualified (post-professional entry) workforces to work to their full scope of practice and to recognise and respect the scope of other members of the multidisciplinary care team. Opportunities include:

- Improving the availability of, and access to, education and training specific to primary care, including opportunities to develop the specific skills required for collaborative care.
- Providing equitable support for students, health professionals, and health service providers to develop and maintain primary care skills, including through primary care student placement experiences and continuing professional development.
- Removing barriers and enabling primary care health professionals to provide quality student learning experiences in partnership with education providers.

Recommendation 2

The Australian Government establish a primary care workforce development program to support the development and retention of a skilled, stable and collaborative primary care workforce through the provision of enhanced curriculum, training/placement and career development capacities for students, supervisors/mentors and primary care health professionals.

Mechanism to achieve change

Establishing a primary care workforce development program would begin with a review of existing programs that achieve similar outcomes. This would provide an understanding of the features of successful programs and identify gaps in the support that is currently available. The review would also highlight where existing programs could be expanded to support additional health professions and/or practice settings.

The primary care workforce development program would provide support where the expansion of existing support cannot be achieved. The program would have targeted streams to provide support for students, supervisors/mentors and health professionals to address the issues highlighted above. The program would be overseen locally by an inclusive team that represents a range of views. This team would engage widely with stakeholders to determine who needs support and how that support would be provided to maximise program outcomes The program would be regularly reviewed, according to defined processes, to further improve the program and ensure it achieves its objectives.

Intended outcomes of the recommendation

The primary care workforce development program will provide support and resources for students, supervisors, mentors and health professionals to develop and maintain their skills in primary care and work to their full scope of practice. The program will ensure that all primary care professions are supported and would remove a range of existing inconsistencies. The program would provide the following benefits:

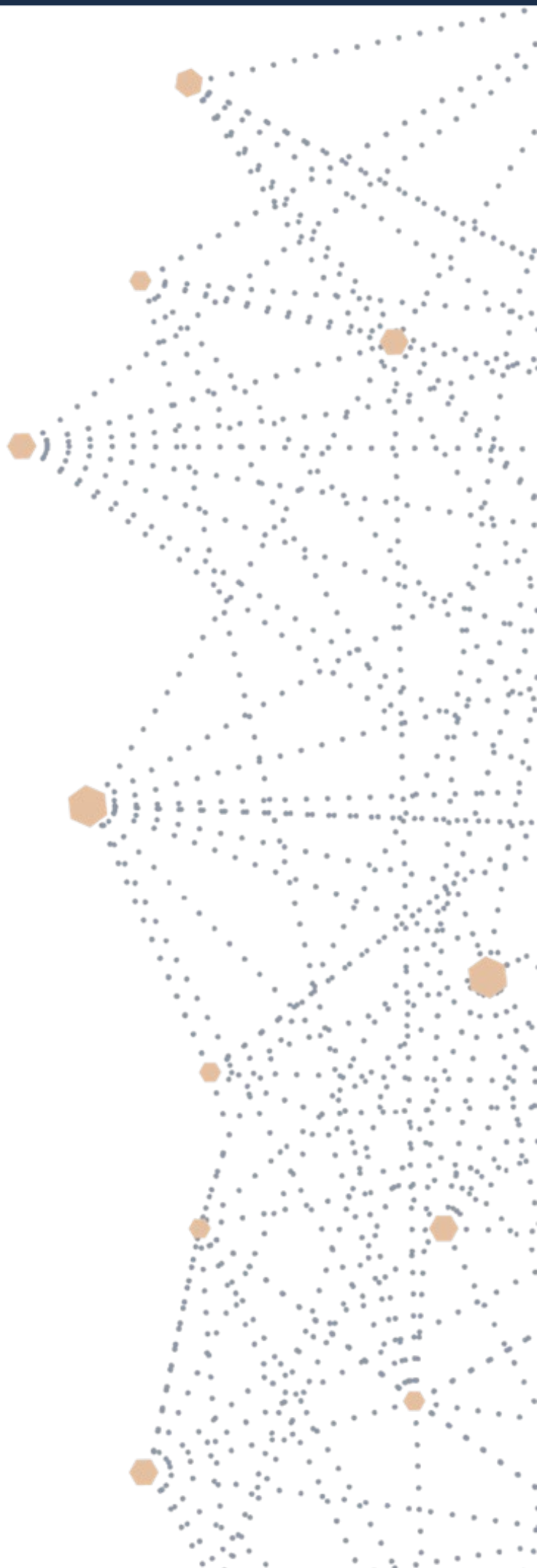
For the consumer

Consumers would benefit from improved access to a highly skilled and supported primary care workforce.

For the multidisciplinary team

Overall, students and health professionals from all professions would be able to access education and training that supports them to provide good quality care and to develop the skills to work together. This would include learning together as a team of different health professionals, which would support all multidisciplinary team members to work collaboratively to their collective full scope of practice. The education program would better support health professionals to move into primary care from other parts of the health system. Health professionals would benefit further from an improved understanding of the scope of practice of other members of the multidisciplinary team.

All health professions would be enabled to provide support for students to complete quality supervised training and develop the skills they need to provide good quality primary care. Supervisors, mentors and peer support workers would be recognised for their role and given specific training and support. Barriers that prevent primary care health professionals from supporting student training would be removed. Students would overall benefit from an improved understanding of primary care and their scope of practice because they are able to complete quality supervised learning in a range of primary care settings.



Amend the National Law to give Health Ministers' Meeting clear, consistent policy authority over both registration and accreditation functions of the National Registration and Accreditation Scheme

Context

Under the National Law, the Health Ministers' Meeting (HMM) can give policy directions to National Boards on matters across their remit. However, in relation to accreditation functions, the HMM's policy direction is limited by the National Law and a policy direction can only be given to a National Board on a particular proposed accreditation standard if:

- in the Ministerial Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners; and
- the Ministerial Council has first given consideration to the potential impact of the Council's direction on the quality and safety of health care.

Issue to be addressed

The National Law restricts the ability of Health Ministers to exercise the full range of policy direction, specifically in relation to accreditation functions outside of the two permissible conditions set out above. This could result in circumstances where the full range of objectives of the National Law may not be translated efficiently or effectively into practice where that policy direction relates to accreditation. This is inconsistent with the more extensive authority of HMM over registration functions.

Recommendation 3

The Health Ministers' Meeting (HMM) agree amendments to the National Law to provide a consistent authority of the HMM to give policy directions to the Australian Health Practitioner Regulation Agency (Ahpra) and National Boards in both registration and accreditation functions.

Mechanism to achieve change

Achieving this recommendation would require an amendment to the National Law.

Intended outcome of the recommendation

This recommendation would expand the policy directions available to the HMM to include those that relate to the accreditation function under the NRAS, consistent with the full range of objectives of the National Law.

For the consumer

Health professionals will have the skills and capabilities they need to provide care that aligns with the policy directions of government so that education programs can better respond to changes in consumer need and professional practice.

For government

Enhanced direct input from Health Ministers to accreditation authorities on relevant matters consistent with the objectives of the National Law.

Establish cross-professional consistency in skill and capability development in common practice areas

Context

Common areas of health professional scope can be identified across professions, including primary care practice, collaborative practice and First Nations health care. There would be benefit in a consistent approach to developing skills and capabilities in these shared areas of practice across professions.

Issue to be addressed

The expected outcomes of education and training are defined by individual professions and may differ.

Inconsistent expectations of education and training in common practice areas may lead to distrust between professions and a poor understanding of the skills and capabilities of members of the multidisciplinary primary care team.

Recommendation 4

Develop principles for IPE and interprofessional capabilities for primary care, collaborative practice and First Nations health care to contribute to contemporary and consistent cross-professional learning and practice.

4.1 The Health Ministers' Meeting (HMM) request accreditation authorities and National Boards reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant Continuing Professional Development (CPD) guidelines and requirements.

4.2 Professional organisations for self-regulated professions reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant CPD requirements.

Mechanism to achieve change

This recommendation requires the development of general principles for IPE and professional capabilities for IPE, collaborative practice and First Nations health care applicable to all professions. The general principles and professional capabilities would inform education and training programs and contribute to greater cross-professional consistency in graduate outcomes.

While many health professions have developed accreditation standards that pertain to the identified practice areas, alignment of accreditation standards with common professional capability descriptions, and/or agreed principles would contribute to greater consistency in graduate skills and capabilities in common practice areas.

Intended outcome of the recommendation

Developing a common goal for education and training in shared practice areas could contribute to greater cross-professional certainty regarding primary care skills and capabilities.

For the consumer

Access to primary care providers with consistent skills and capabilities in shared areas of practice. Consumers can be assured that all primary care health professionals are equipped with skills that support these areas of practice.

For the multidisciplinary team

The team would benefit from an improved consistency in the skills and capabilities health professionals have in shared practice areas. This consistency could enable enhanced team trust, cohesion and function.

For the education provider and accreditation authority

Clarity regarding the expected goals of education and training programs, including the skills and capabilities to be included in the curriculum, including in assessment.

Remove unnecessary barriers to supervision in primary care education and training

Context

In some health care settings, cross-professional supervision can enable quality student learning and provide an alternative view of care than that provided by discipline-specific supervision. Cross-professional supervision can broaden the student view and contribute to their skill development but should not replace discipline-specific supervision.

Opportunities for practical learning (also known as 'placement') in primary care are important for students to develop the skills they need to provide good quality primary care. This type of learning also contributes to a skilled and stable primary care workforce where health professionals feel confident and equipped to provide care. However, for many health professions, a large proportion of practical learning is provided in hospitals. While practical training in hospitals is important, it generally does not develop the specific skills and knowledge needed for primary care.

Issue to be addressed

Cross-professional supervision should be supported to complement, but not replace, profession-specific supervision. This should be reflected in accreditation standards and training guidelines.

Supervising health professionals are necessary to support training of students. For some primary care professions, providing student learning opportunities may result in financial cost to the supervisor due to uncertainty regarding eligibility for MBS rebates where a student is involved in the consultation. Generally, MBS items require services to be delivered by eligible practitioners (with a Medicare provider number) to eligible patients and students do not meet the definition of an 'eligible practitioner'. A strict interpretation of this rule limits practical opportunities for students to learn and develop their skills and capabilities under supervision. To support patient safety and optimal educational outcomes, while maintaining practice viability, a review of MBS billing rules that apply where students are involved in the consultation is required.

Recommendation 5

Remove unnecessary barriers to supervision in primary care education and training, including those that impede cross-professional supervision.

5.1 The Health Ministers' Meeting (HMM) request National Boards and accreditation authorities enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.

5.2 Professional associations for self-regulated health professions enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.

5.3 The Australian Government review Medicare Benefits Schedule (MBS) rules and guidelines to ensure that all health professions are reasonably and equitably supported to undertake workplace-based placement supervision in primary care.

Mechanism to achieve change

To achieve this recommendation, health profession accreditation authorities would review and amend existing accreditation standards and guidelines that require the exclusive provision of profession-specific student supervision during practical training opportunities. In addition, a review of, and amendment to, the MBS funding rules that act as a barrier to providing students training in primary care would be required.

Intended outcome of the recommendation

This recommendation would enable greater flexibility in student supervision, contribute to student appreciation for the role, expertise and view of other professions, and facilitate training opportunities in situations where this may have previously not have been possible.

For the consumer

Cross-professional supervision would enable improved training experiences and the development of skilled primary care professionals who appreciate the role of other health professions and have benefited from the opportunity to develop the skills required for primary care practice.

A greater number of students completing primary care placements may enable health professionals to offer additional services or provide more intensive interventions.

For the education provider

Greater scope for the provision of primary care training opportunities that support student development.

For the student

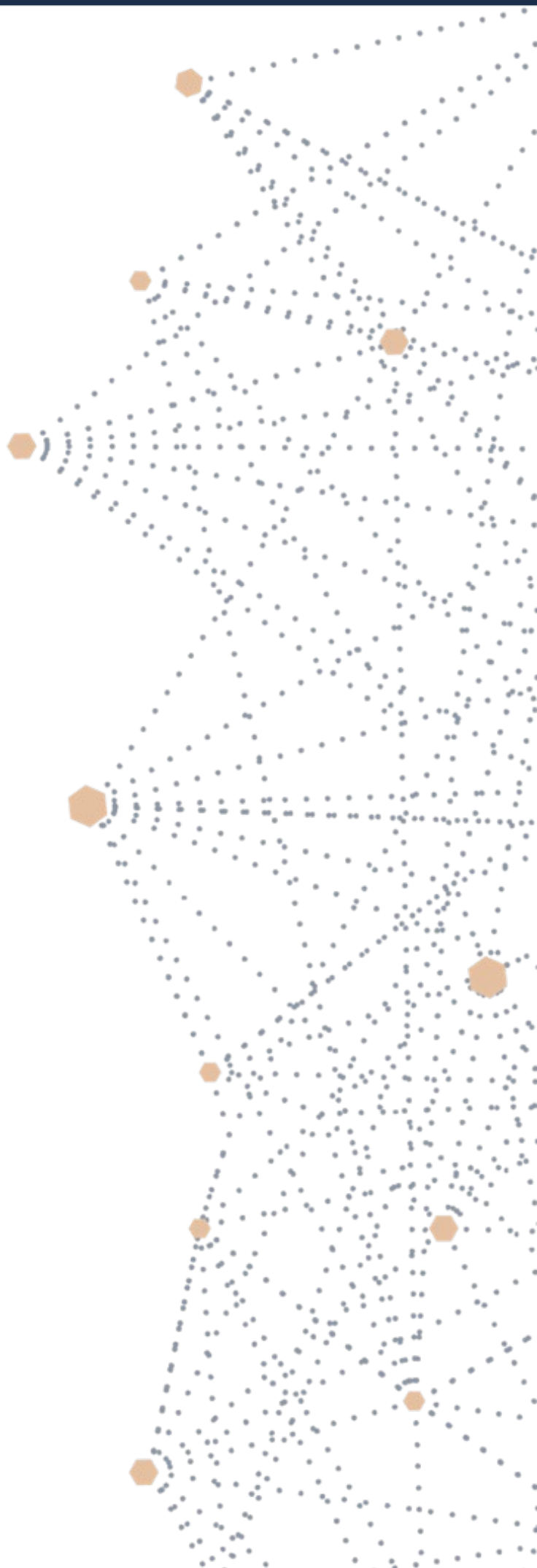
Students benefit from an alternative professional view of care and a broadened understanding of the primary care health system. Cross-professional supervision may also support training experiences that would otherwise not be possible.

For the multidisciplinary team

The opportunity to supervise students from other professions could enhance health professional appreciation of role and capability and contribute to an improved team function.

A greater number of primary care health professionals contributing to practical training would enable more student placements in primary care and the development of a skilled primary care workforce better prepared to work at full scope of practice.

Providing learning opportunities for students may bring a fresh, different and evidence-based perspective to consumer care, as well as greater diversity and representation to the primary care team.



Progress activity-based regulation of scope of practice to complement the status quo protection of title approach

Context

Legislation and regulation shape the authorising environment which informs health professionals' ability to work to their full scope of practice. The National Law and the NRAS form a significant part of this environment and are serving the intended purpose of protecting public safety, whilst also enabling full scope of practice. However, a wide range of broader legislative and regulatory instruments are associated with significant scope of practice barriers experienced by health professionals, particularly those who are not named in the National Law.

Issue to be addressed

Commonwealth, State and Territory Government legislation and regulatory instruments (unrelated to the National Law or NRAS) are prescriptive 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. This results in circumstances where health professionals are prevented from performing activities within their scope of practice in circumstances where it would be safe to do so.

The prescriptiveness of legislative and regulatory instruments also results in a high degree of rigidity in the legislative and regulatory environment which acts as a barrier to reflecting emerging or changing best practice.

Recommendation 6

Health Ministers agree to progress activity-based regulation of scope of practice to complement the status quo protection of title approach. This would apply in instances where a clinical activity that is to be regulated through Australian, state or Territory legislation, excluding the National Law or National Registration and Accreditation Scheme (NRAS):

- Is effectively common or shared across a number of health professions, or has the potential to be
- Is a novel clinical activity not currently performed or undertaken only by a single discipline
- Meets an appropriate risk threshold
- Is in the public interest consistent with the objectives of the National Law, S3 (2) [a-f].

6.1 Health Ministers agree to prospectively:

- limit in future legislation and regulation the use of protected titles as the primary means of regulating and restricting activities in legislation unrelated to the National Law or the direct regulation of health professionals, i.e. shorthand references - and instead
- adopt an approach based on assessment and management of the inherent risk associated with the activity being regulated or restricted.

6.2 The Health Ministers' Meeting (HMM) request National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) to commence identification of activities falling within an overlapping scope across professions, to inform relevant programs of review and potential harmonisation of existing legislation and regulation (see Recommendation 7), guidelines and standards, and/or education programs.

Mechanism to achieve change

An activity-based approach to regulating scope of practice would play a complementary role to existing protection of title. The approach would start with a process of identifying activities to which the activity-based regulation (ABR) would apply. These activities would include those which are shared across professions (or have the potential to be) and which meet the risk threshold and public interest criteria described in Recommendation 6.

The ABR approach is proposed to inform relevant programs of review and potential harmonisation of:

- existing legislation and regulation, particularly through removal of unnecessary shorthand references to the National Law (see Recommendation 7)
- guidelines, standards, and/or education programs, where these are overly reliant on the use of named professions in a way which is exclusionary of professions which have that role within their scope of practice.

Intended outcome of the recommendation

For the consumer

Consumers stand to benefit from increased access to common types of primary care which are enabled to be delivered by a potentially broader range of health professionals.

For the multidisciplinary team

A commitment to a more balanced approach to regulating scope of practice, which does not rely solely on title protection, in future legislation and regulation would help to address the high degree of rigidity within the legislative and regulatory environment. The combined reforms seek to improve and clarify the authorising environment which enables health professionals to carry out activities already within their scope of practice, by removing unnecessary legislative and regulatory barriers.

Agree to a program of review and potential harmonisation of existing legislation and regulation

Context

Health professional scope of practice is shaped in part by legislation and regulation. Across Australia, the way governments legislate or regulate the same subject is often different. This can mean that the activities that a practitioner is authorised to deliver can be different depending on where they work and, for consumers, access to care can be different depending on where they live. Common examples of these different approaches include different definitions relevant to health professional scope of practice.

Legislation also impacts health professional practice through the pervasive use of shorthand reference to health professions that are members of the NRAS, thereby excluding those who practise outside the scheme. Commonly, this relates to specific activities within a given area of legislation, and may include activities for which a health profession has proven competence.

Issue to be addressed

Inconsistent authorisations and definitions identified in legislation and regulation present a barrier to health professionals working to their full scope of practice. This issue results in complexity and confusion in understanding their own and other professions' scopes of practice, particularly across jurisdictional borders, and materially and negatively impacts health professions' ability to carry out activities for which they are educated and competent.

The pervasive use of shorthand references to the National Law in legislation and regulation represents a major scope of practice barrier on a system level, which works against the enabling intent of the NRAS. This has a significant impact on non-registered professions' ability to practice to their full scope of practice, particularly in unnecessarily preventing self-regulated professions from carrying out a range of activities which fall within their scope.

Recommendation 7

Health Ministers agree to a program of review and potential harmonisation of existing legislation and regulation which:

- contain unnecessarily restrictive application of shorthand references
- if replaced by an activity focused approach (see Recommendation 6), would enable a wider range of health professionals to undertake the restricted activity consistent with their scope and in the public interest.

7.1 Commence the program review and potential harmonisation of existing legislation and regulation with the following:

- Drugs and Poisons Acts
- Radiation Safety Act
- Mental Health Acts.

Mechanism to achieve change

To achieve this recommendation, a comprehensive review of existing legislation and regulation that pertains to health professional practice would be undertaken with a view to identifying areas where health professions are referred to in a shorthand reference that excludes those who practise outside the NRAS. The review would initially focus on areas with the potential to most materially impact scope of practice (commencing with drugs and poisons legislation) and focus on shorthand references to the National Law and broader definitional inconsistencies between jurisdictions. Subsequently, a process of harmonising legislation and regulation to support greater consistency in health professional legislation and regulation would be undertaken.

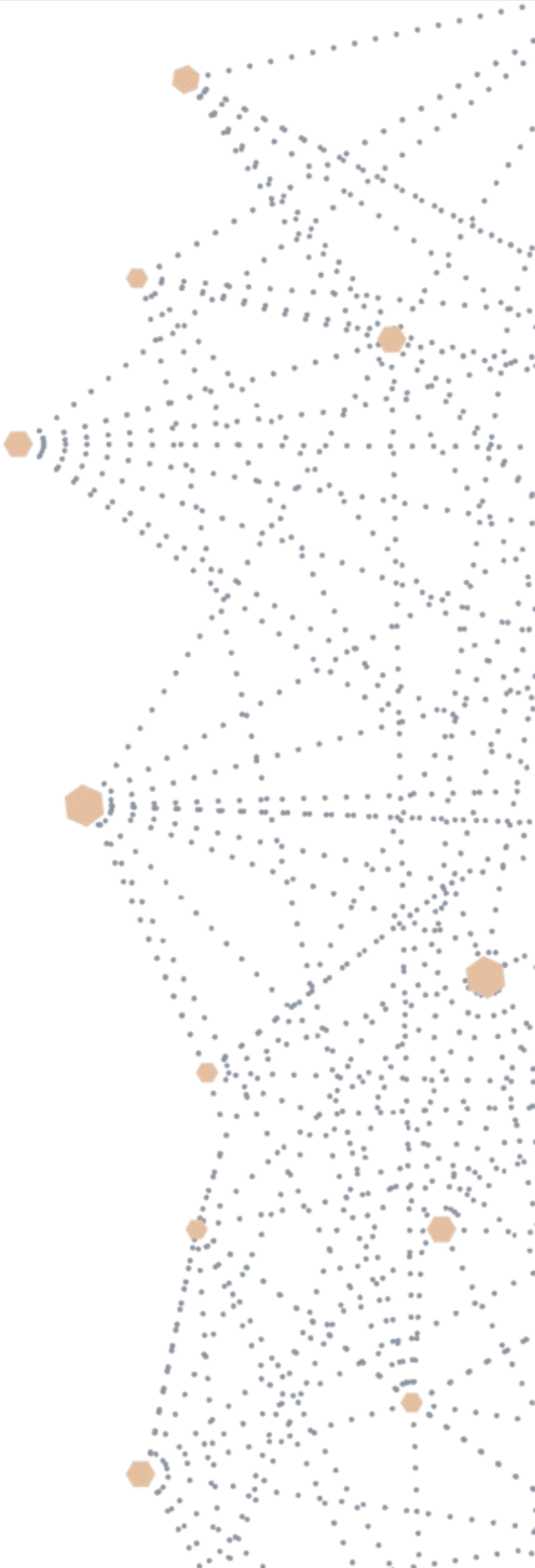
Intended outcome of the recommendation

For the consumer

Consumers stand to benefit from improved clarity around which health professionals are authorised to deliver aspects of care. They are likely to benefit from increased equity of access across jurisdictions, particularly those who access primary care in more than one jurisdiction, because scope of practice authorisations will be made more consistent across the country.

For the multidisciplinary team

Improving and clarifying the authorising environment would enable health professionals to perform activities that fall within their scope of practice but for which they are ineligible to currently undertake, by removing unnecessary legislative and regulatory barriers relating to references to protected titles and by commencing work with harmonising legislation and regulation which has the most significant material impact on scope of practice.



Strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation Scheme (NRAS)

Context

Self-regulated professions are regulated by profession-specific colleges and associations and are not regulated under the NRAS. Their status as self-regulated professions means they do not have statutory title protection and are automatically excluded from any legislation or regulations which make shorthand reference to the National Law to define the health profession or practitioner. Assessment for entry of additional professions into the NRAS follows a two-step process during which professions must demonstrate their occupation poses 'significant risk of harm to the health and safety of the public', and that benefits of regulation clearly outweigh the potential negative impacts (via a Regulatory Impact Assessment (RIA)).

Issue to be addressed

Evidence strongly points to self-regulated professions being precluded from performing activities for which they are competent to perform, and which are within scope. This is due not only to the widespread practice of shorthand references to the National Law (which are themselves not made in a consistent way across legislation and regulation), but to broader issues of interprofessional recognition and understanding. These issues are unlikely to be wholly addressed through the review or harmonisation of legislation alone (as in Recommendations 6 and 7).

This regulatory practice impacts professional scope of practice for self-regulated professions, and their inclusion in multidisciplinary team-based care more broadly. Ultimately, not making full use of the self-regulated professions limits the flexibility, responsiveness and sustainability of the entire Australian health workforce. For consumers, this can result in reduced access to primary care, as some health professionals who are competent to deliver aspects of their care may be prevented from doing so.

Recommendation 8

The Health Ministers' Meeting (HMM) agree to strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation Scheme (NRAS) to:

- enable the community to access and benefit from all health professionals working to their full scope of practice in multidisciplinary teams in primary care
- ensure safety and quality of care delivered by the self-regulated health professions.

8.1 HMM agree to commission a rapid impact analysis of the three reform options to determine which option/s meet the criteria defined above and is cost-effective:

- **Option A** – targeted legislative amendments to introduce a pathway into NRAS by introducing an additional criterion, such as a 'public interest' criterion, to the NRAS criteria for regulatory assessment of the need for statutory registration of a health profession
- **Option B** – amended definition of a 'health profession' by amending the National Law to include additional specified professions in the definition of a 'health profession'
- **Option C** – accreditation by the Australia Health Practitioner Regulation Agency (Ahpra) (or another body) of relevant professional bodies to perform consistent, quality self-regulation functions for professions which are not registered in the NRAS.

Mechanism to achieve change

To fully address scope of practice issues for self-regulated professions, a range of potential reform options are available to formalise their professional scopes and roles:

- **Option A** – targeted legislative amendments to introduce a pathway into NRAS, by introducing an additional criterion to the regulatory assessment process. This option provides national registration and title protection for self-regulated professions and would require the establishment of new National Board(s) (either separate or multidisciplinary).
- **Option B** – amended definition of a 'health profession' in the National Law, to include additional specified professions in the definition of a 'health profession'. This option could be implemented in a targeted manner; however, it may be relatively limited in its impact, due to the inconsistency in how various legislation and regulation make shorthand reference to the National Law, and the fact that many of these references are to 'registered professions', which this option would not resolve.
- **Option C** – external accreditation of professional bodies to perform regulatory functions including maintenance of voluntary practitioner registers, determine education and training accreditation standards, professional capabilities etc. This would introduce a strengthened, national approach to regulation other than full statutory registration. This option would incorporate a new external accreditation and certification role for Ahpra over national self-regulating entities, who would maintain control of self-regulatory functions. This may also take the form of a voluntary register of health professions. Effectively, this model introduces a new tier of regulation intended as a proportionate response to the call for statutory registration of additional health professions. The National Law would need to be amended to make reference to the professions which fall within this 'third tier', and to enable Ahpra to undertake the external accreditation and certification role.

Regardless of which options (A-C) are under consideration, an Impact Analysis would be required (either or both of a Policy Impact Analysis or Regulatory Impact Analysis) to determine a preferred option.

Intended outcome of the recommendation

For the consumer

Regardless of which reform option is progressed, this recommendation will help to ensure improved access to care delivered by self-regulated health professions. It is also likely to result in greater public confidence in the scope of practice of self-regulated professions by introducing greater transparency and certainty through the chosen mechanism.

For the multidisciplinary team

All reform options are intended to improve interprofessional understanding and inclusion of self-regulated health professionals in multidisciplinary team-based care, thereby improving their ability to work to full scope of practice.

Establish an Independent Mechanism to provide evidence-based advice on workforce innovation

Context

Effective service delivery requires workforce development and planning informed by a comprehensive, data-driven, evidence-based understanding of the services and workforce required. This occurs in an ad hoc, predominantly siloed way, including through National Boards and equivalent professional organisations. This Review found there is a need to view the health system as a more cohesive whole, consistent with the findings of the NHRA mid-term review.

Issue to be addressed

Progressing significant evidence-based reforms to scope of practice has proven to be an unnecessarily complex process, due to a highly prescriptive and inflexible legislative and regulatory environment, program restrictions and payment rules. Moreover, professional organisations such as National Boards face challenges in progressing proposals for significant practice change. These issues all work to prevent the timely adoption of better practice and innovative workforce models of care.

Recommendation 9

Establish an Independent Mechanism to provide evidence-based advice and recommendations to the Health Ministers' Meeting (HMM), Ministers, government and key stakeholder groups in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope, that:

- Are high risk, or
- Offer significant improvements to service access, consumer experience or productivity.

9.1 Independent Mechanism to hold responsibility for developing the National Skills and Capability Framework and Matrix (Recommendation 1) as a priority initial activity.

Mechanism to achieve change

The Independent Mechanism would function as a proactive, independent advisory body that provides advice to Ministers, governments, National Boards and regulators to enable objective assessment of evidence in support of significant health workforce innovation, including in relation to proposals for significant change to scopes of practice. There is a clear potential role for the Independent Mechanism in housing and maintaining the proposed National Skills and Capability Framework and Matrix (see Recommendation 1).

The Independent Mechanism would have either a legislative or administrative foundation that enshrines its purpose. A bidirectional relationship would exist between the Independent Mechanism and National Boards/professional associations. Members, appointed by Health Ministers, would be independent and not representative of government, industry or organisations.

Intended outcome of the recommendation

For the consumer

The Independent Mechanism would enable greater transparency in evidence-based decision-making about scope of practice, including the considerations on decisions to change a scope of practice in line with community need.

For the multidisciplinary team

The Independent Mechanism would support innovation and excellence in health workforce design, and improve system responsiveness to legislative and regulatory change, enabling scope of practice innovation to translate more efficiently and effectively into practice on the ground.

Introduce funding and payment models to enable and support health professionals in multidisciplinary care teams to work to full scope of practice

Context

Funding and payment models are a powerful determinant of health professionals' scope of practice. The long-standing fee-for-service arrangement in Australia is the principal payment model for the primary care sector. This payment mechanism incentivises episodic, high-turnover care because the number and type of episodes of care determine the amount paid to the health care provider.

Existing good practice examples of primary care, such as ACCHOs and services in rural and remote settings, illustrate the advantages of more flexible funding streams in supporting multidisciplinary primary care teams working to full scope of practice. The communities serviced by these models also tend to be more negatively impacted by barriers to their health professionals working to full scope of practice, reinforcing the need for primary care funding models to carefully account for their needs.

Issue to be addressed

Current funding rules are prescriptive about which health professionals are funded and paid to deliver certain activities. This has 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. This payment system does not adequately support the multidisciplinary model of care which aligns with the policy intent of *Strengthening Medicare Taskforce Review.* Introducing more flexible payment models to complement the predominantly fee-for-service payment model in primary care would better support primary care professionals to meet consumers' health care needs (particularly complex health needs).

Recommendation 10

Introduce a new blended payment to enable access to multidisciplinary health care delivered by health professionals working to their full scope of practice in primary care. This new payment would be supported by a significant growth in investment in primary care and would shift the mix of Australian Government payments for primary care from a 90:10 fee-for-service: blended payment to 60:40 (at an aggregate national level).

10.1 Fundholding entities for the new blended payment include practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs) to fund and support a flexible mix of health services to meet the local health needs of their registered population.

10.2 Establish access requirements for the blended payment as follows:

- Patients must be registered with a health care provider via MyMedicare
- Participating health professionals must be part of a team [broadly defined] or clinical network
- Digital infrastructure must be adopted to enable clinical team processes such as secure messaging, instant event notifications, results reporting and articulation with My Health Record
- Affordable access for registered patients to an appropriate suite of multidisciplinary health services provided by health professionals operating at full scope.

10.3 Progressively incorporate a range of existing Australian Government, practice, program, Medicare benefits Schedule (MBS) and PHN commissioning payments into the blended payment.

10.4 Introduce a new practice level transition payment to ensure that the move from 90:10 to 60:40 ratio is supported by real growth in primary care investment which:

- Enables smooth implementation and change management at the practice, profession and population levels

- Makes appropriate and equitable adjustments at the fundholder level for historical underutilisation of MBS and other primary care programs due to long-standing General Practitioner (GP), nursing and allied health shortage
- Incentivises establishment and spread of innovative multidisciplinary models of care, including rural generalists, nurse-led, allied health-led and midwifery-led clinics, and advanced remote service delivery models, to better serve rural, remote and underserviced populations.

10.5 Establish an independent, specialised mechanism, or utilise an existing entity (such as Independent Hospital and Aged Care Pricing Authority) to advise on the pricing and payment levels of the blended payment. The mechanism would provide ongoing advice to the Australian Government on:

- Design, calculation and maintenance of risk stratification for the blended payment, based on the profile of registered patients at the practice population and fundholder level
- Prospective pricing adjustments and indexation of the blended payment.

10.6 For historically underserviced areas with minimal or no access to MBS billing, GPs and health professionals implement an alternative registration model to ensure equitable access to the blended payment as the primary payment mechanism for Australian Government primary care programs.

10.7 Incorporate the blended payment model into a new reform schedule of the National Health Reform Agreement (NHRA) to enable appropriate participation by and eligibility for State and Territory Local Health Networks (LHNs) and PHNs.

10.8 Implement the blended payment model in a staged program over seven years commencing with the following priority areas:

- Rural and remote regions (Modified Monash Model (MMM) 5-7)
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- Underserviced regional and outer metropolitan areas
- Other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserviced communities and population groups

Mechanism to achieve change

The blended payment is proposed to progressively combine and refocus 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. This payment would be available to practices [3] to support a flexible mix of health services that meet the local health needs of their registered population (i.e. MyMedicare registrations).

Over time and at a national level, the government funding for primary care is proposed to shift towards a 60:40 ratio (fee-for-service funding to new blended funding). The blended payment will have specific requirements including association with a multidisciplinary care team, as broadly defined, and underpinned by a newly-established risk adjustment mechanism and compliance and performance evaluation metrics.

Implementation is proposed to follow a seven-year transition pathway, supported by a new transitional payment to practices during the rebasing of funding. to Address entrenched access gaps, implementation of the model is to be commenced in communities facing the greatest primary care access and equity challenges, including rural and remote regions.

Intended outcome of the recommendation

For the consumer

Shifting the system towards a risk-adjusted blended payment model, over time, would allow individual health professionals to be more responsive to each consumer's unique needs, and to work together with other health professionals in their multidisciplinary care team to ensure these needs can be met.

For health professionals

With the introduction of a blended payment, practices will have greater flexibility to employ or engage different health professionals to contribute to the multidisciplinary health care team and work to their full scope of practice. Blended funding would also be expected to better value wraparound aspects of primary care, care planning and coordination.

[3] Defined as practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), PHNs and ACCHOs

Introduce a bundled payment for maternity services

Context

It is common for a consumer accessing maternity care to move across primary care and acute care at relevant parts of a normal maternity care pathway, including newborn care. A 2017 Independent Health and Aged Care Pricing Authority (IHACPA) review of bundled pricing for maternity care found midwifery continuity of care models internationally are associated with a range of benefits and could drive change and innovation in how maternity services are delivered.

Issue to be addressed

Currently, it can be difficult for the maternity care team to continue to provide care to the woman and baby when the care setting changes. This can have a negative impact on their experience of care.

The introduction of a bundled payment for maternity services, including midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model as defined care pathways, would fund and enable the maternity care team to work to their full scope when they practice across different parts of the health care system (including primary care and hospital care), which currently operate under separate funding arrangements.

Recommendation 11

Introduce a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a General Practitioner (GP) shared care model for combined, integrated, woman-centred care provided in primary care and public hospital settings.

11.1 Introduce a private sector version of the bundled payment for maternity care. Amend the *Private Health Insurance Act* and *Health Insurance Act 1973* to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings.

Mechanism to achieve change

The bundled payment would be inclusive of and apply to more than one form of maternity service associated with midwifery continuity of care models (including Birthing on Country). The payment is required to be risk-stratified in recognition of the range of complexity to which this model of care may apply.

Both public and private sector models are proposed. In the public sector model, the bundled payment would be made to the Local Health Network or equivalent. In the private sector model, the change would be more significant and would involve establishment and recognition of a new hybrid Private Health Insurance product spanning hospital and primary care.

To prioritise meeting the needs of communities affected by historical underservicing, the rollout will be commenced in selected rural, remote and metro areas to evaluate effectiveness before being fully implemented across the system.

Intended outcome of the recommendation

For consumers

Consumers will receive more continuous and connected care from the maternity care team involved in their journey across primary, acute, public and private settings.

For midwives

Midwives can be expected to experience improved mobility and support to work across different settings, and removal of funding-related barriers to working to full scope of practice within those settings.

For obstetricians and GPs

A funding and payment model which better supports integrated and shared care models across the primary and hospital care settings.

Implement direct referral pathways supported by technology

Context

Payment rules about which health professions can provide referrals to non-GP medical specialists are tightly defined under the *Health Insurance Act 1973* (Health Insurance Act) and associated regulations. Under these rules, consumers referred to as non-GP medical specialists including imaging or pathology, cannot receive MBS benefits for that service unless the referral was provided by a defined health professional under specified circumstances. In most instances, the referring health professional is required to direct the consumer to a GP who then makes the referral to the non-GP medical specialists.

Issue to be addressed

Outside of referrals provided by specific named professions, these regulations prevent the consumer from being eligible for MBS benefits for the referred service, resulting in out-of-pocket costs by default. For consumers, this creates both cost and time barriers to accessing primary care because, despite receiving care and referral advice from a health professional of their choice, they are often required to undertake a secondary consultation (typically with a GP) to access the required referral.

Recommendation 12

The Australian Government implement new direct referral pathways for consumer access to specified non-General Practitioner (GP) specialist Medicare Benefits Schedule (MBS) items which meet the following criteria:

A. The direct referral made by the health professional is within their 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, and registered practice via digital mechanisms as available.

In the first instance, these are recommended to include:

Allied health

- Physiotherapist, chiropractor, and osteopath referral to orthopaedic surgeon (e.g. when conversative management is not successful or where the patient presents with an acute or serious injury)
- Audiologist and Speech Pathologist referral to an ENT (Ear Nose Throat) surgeon (e.g. where an underlying medical condition is suspected as contributing to the speech, hearing or auditory system issues the patient is experiencing and medical treatment, including surgery, may be required)
- Psychologist referral to psychiatrist (e.g. where the complexity of the person's mental health condition requires additional support and/or is likely to benefit from a medication program or management)
- Dietitian referral to gastroenterologist (e.g. where the person has a gastroenterological condition requiring specialist support)
- Diabetes educator referral to endocrinologist (e.g. where there is evidence of poorly controlled diabetes or major hypoglycaemia episodes or other vascular complications)

- Podiatrist referral to vascular surgeon (e.g. for the management of diabetic foot disease)
- Accredited hand therapist referral to hand surgeon and plastic surgeon (e.g. where clinically indicated due to fractures, tendon ruptures and other conditions).

Midwife referral to:

- Obstetric Physician (e.g. for Gestational Diabetes Management where there is evidence of gestational diabetes)
- Maternal Fetal Medicine specialist (e.g. for complex maternal or neonatal conditions, such as exomphalos, genetic anomalies)
- Anaesthetist (e.g. for epidural where required)
- Psychiatrist (e.g. where there is evidence of perinatal psychosis).

Nurse Practitioner referral to:

- Psychiatrist (e.g. for complex, high level assessment, treatment and prescribing)
- Geriatrician (e.g. for cognitive decline, depression and anxiety)
- Urologist (e.g. for prostate and other urinary tract issues)
- Gynaecologist (e.g. for reproductive health).

Remote Area Nurse referral to:

- Medical Specialist (according to need and context).

Mechanism to achieve change

A number of appropriate direct referral pathways emerged from the combined evidence. These are high-volume referral pathways currently subject to requirement of GP involvement despite being clearly understood to fall within the scope of practice of another health professional. Expanded referral pathways are proposed to be conditional on the health professionals making and receiving the referral being part of a broadly defined clinical team or clinical network. To minimise the risk of fragmentation, timely notification of the consultation to relevant treating team members (including the patient's GP) is a further condition, preferably via digital mechanisms as available.

To prioritise meeting the needs of communities affected by historical underservicing, the rollout will be commenced in selected rural, remote and metro areas to evaluate effectiveness before being fully implemented across the system.

Intended outcome of the recommendation

For the consumer

More streamlined access to primary care services by addressing common administrative and affordability access barriers. Additional GP appointment slots are freed up for patients improving overall access to primary care.

For the multidisciplinary care team

Expanded direct referral pathways are intended to enable health professionals to make specific types of direct referrals, thereby enhancing their ability to work closer to their full scope of practice.

For general practice

A significant volume of potentially unnecessary or low value appointment slots can be freed up to support other patients requiring access to their GP.

Commit to drive culture, leadership and implementation support across the primary care system

Context

Culture and leadership change must occur at all levels to drive the aim of this Review in strengthening multidisciplinary care teams to work to full scope of practice.

Issue to be addressed

The Review found there is a need for a strengthened culture of understanding and trust between professions, without which primary care consumers will experience ongoing barriers to access and continuity of care. To achieve this cultural shift, all key stakeholders will need to work together with a much greater focus on interprofessional collaboration.

Recommendation 13

Governments and key stakeholders commit and agree to progress the required reform program and governance structure to drive culture, leadership, implementation support and evaluation across the primary care system.

13.1 Australian, State and Territory Governments agree to incorporate all relevant recommendations from this Review into the upcoming National Health Reform Agreement (NHRA), specifically into the respective schedules of the agreement which address agreed health system reforms.

Mechanism to achieve change

Australian, State and Territory governments should align in their commitment and leadership to progress the reform agenda and must rise above professional siloes to do so. This should be met with a commitment within primary care services and teams to work in a genuinely multidisciplinary way, breaking down traditional hierarchies.

A commitment to embed consumer consultation must underpin the implementation of all reforms, as will dedicated evaluation and monitoring mechanisms.

Intended outcome of the recommendation

For the multidisciplinary care team

A shared commitment from leadership to progress reforms outlined in this report will support cultural change across the primary care sector. It will support the conditions which allow primary care professionals to work to their full scope of practice.

For the consumer

This, in turn, will enable more people to access primary care from multidisciplinary care teams who work in a collaborative manner, to experience fewer barriers related to interprofessional culture and therefore receive care which better meets their needs.

Develop a capacity building and implementation support program for Primary Health Networks

Context

PHNs are a key institutional mechanism to support and integrate primary care policy and programs. There is an opportunity for PHNs to strengthen their change management role in the primary care system.

Issue to be addressed

Capability uplift will be required within PHNs to ensure they are able to support local primary care systems in a consistent way according to community need. Similarly, the proposed strengthened role for PHNs in supporting clinical governance in primary care would need to be supported by capability uplift.

Recommendation 14

The Australian Government develops a new capacity building and implementation support program for the 31 Primary Health Network (PHNs) that will complement their existing planning, integration, practice support and commissioning functions in the primary care system. Specifically, these include:

A2 Strengthen the capability of the primary care workforce (Recommendation 2)

C1 Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice (Recommendations 10 and 11)

C2 Direct referral pathways supported by technology (Recommendation 12)

D1 Culture and leadership (Recommendation 13)

D2 Program governance, change management and evaluation (Recommendations 13 and 15)

D4 Clinical governance and risk management (Recommendation 17)

D5 Rural and remote focus (Recommendation 18).

Mechanism to achieve change

The Australian Government will work with PHNs to develop the capacity building and implementation support program to promote the required skills at a PHN level to deliver the suite of reforms. This should be delivered in a way which is cognisant of how programs are delivered according to local contexts.

Intended outcome of the recommendation

For the primary care system

PHNs will benefit from being better supported to deliver against additional roles and expectations. This will enable them to support clinical governance, workforce, and funding and payment policy reforms in a more consistent way across jurisdictions.

For consumers

A consistent support structure for primary care reforms will ultimately support consumers by improving the efficiency and effectiveness with which change can be achieved. Consumers are expected to, in turn, experience improved access to multidisciplinary care, with a positive impact on health outcomes.

Implement a change management strategy with embedded consumer engagement to support reforms

Context

Change is required at a large scale and across all levels to progress the reforms and promote a positive system-wide culture called for by this Review. This will require a dedicated change management strategy. The important role consumers play in implementation was reinforced throughout this Review, as was the importance of evaluation and monitoring.

Issue to be addressed

A coordinated governance and change management program is critical to ensure all key stakeholders have an understanding of why the reforms are important, and the expectations on them. Program design and implementation should be informed by consumer and community perspectives and needs and include mechanisms to evaluate whether intended outcomes are being achieved.

Recommendation 15

Governments, working with relevant professional associations, develop and implement communications and training strategies about the intent and substance of reforms to strengthen multidisciplinary primary care teams working to full scope of practice.

15.1 Embed a consumer co-design and consultation element in design and implementation phases associated with all recommendations.

Mechanism to achieve change

Significant and ongoing engagement, through the development and dissemination of communications and training materials, will be required across all parts of the primary care sector to support change management during the rollout of reforms. These materials will reinforce the multidisciplinary care team as the optimal mode of delivering primary care and should be informed by consumer participation to co-design the materials.

The implementation approach attached to all recommendations will further inform this recommendation:

- Continuous consumer involvement in design and implementation is embedded in the implementation of all recommendations, ensuring community needs and lived experience are kept at the centre of reform
- Ongoing evaluation and monitoring must be attached to each program to systematically assess the extent to which they are meeting intended objectives and are, overall, contributing to health outcomes in the community.

Intended outcome of the recommendation

For the primary care system

A coordinated approach to communications and training will enable all stakeholders to have a consistent understanding of the change required, why it is needed, and their role in driving the change. Program governance which supports more streamlined implementation efforts will help to minimise the burden on stakeholders during the transition to new programs.

For consumers

Consumers will have confidence that their needs are being considered at the core of program design and implementation. Ultimately, the sum of reforms stands to benefit all community members through the provision of stronger multidisciplinary team-based care.

Commit to a shared definition of cultural safety across primary care

Context

Cultural safety is the shared responsibility of all primary care professionals to uphold, in order for First Nations community needs to be addressed. A shared definition of cultural safety across the National Registration and Accreditation Scheme was developed as part of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. It is a critical step towards eliminating racism against First Nations peoples in health care, moving towards a right-based approach to health care, and demonstrating ongoing commitment to learning.

Issue to be addressed

The Review heard evidence of a lack of interprofessional recognition and respect for Aboriginal and Torres Strait Islander Health Professionals, translating into barriers to their ability to work to full scope of practice. This has potentially serious flow-on impacts on First Nations peoples' access to culturally safe primary care.

Recommendation 16

The Health Ministers' Meeting (HMM) agree to progress work in partnership with First Nations stakeholders to commit to a shared definition of cultural safety across primary care, based on the definition of cultural safety for the National Registration and Accreditation Scheme (NRAS).

16.1 The Health Ministers' Meeting (HMM) agree to incorporate cultural safety as a foundational shared capability in the first iteration of the National Skills and Capability Framework and Matrix (Recommendation 1).

Mechanism to achieve change

In agreeing to progress a shared definition of cultural safety across primary care, the Health Ministers are committing to a significant program of engagement with First Nations and other key sector stakeholders. This process should be First Nations-led to ensure it reflects self-determination, including a consumer consultation element.

A shared commitment to cultural safety is proposed to be formalised by incorporating a shared capability into the first iteration of the National Skills and Capability Framework and Matrix. It is noted that significant community consultation and co-design also needs to inform this process.

Within primary care services and teams, the above efforts need to be met with an ongoing commitment to learning and to challenging assumptions and biases about how primary care should be delivered.

Intended outcome of the recommendation

For the multidisciplinary care team

First Nations health professionals benefit from a more inclusive and informed multidisciplinary team-based care environment in which they are consistently enabled to work to full scope of practice, without encountering interprofessional racism or other barriers related to culture. All primary care professionals stand to benefit from a more informed approach to working with First Nations colleagues and with First Nations communities.

For First Nations communities

Improved understanding and demonstration of cultural safety across the system ultimately enables more First Nations communities to access appropriate and safe primary care, a necessity for improved community health outcomes.

Mandate participation in quality and safety standards accreditation programs

Context

Robust clinical governance mechanisms are key to primary care safety, quality and excellence. Clinical governance tends to look different across the primary care sector than in other parts of the health system, because the business structure of primary care is more dispersed and disaggregated. The Australian Commission on Safety and Quality in Health Care (ACSQHC) plays an important role in health care standards, clinical governance and risk management at a whole-of-system level. It is responsible for the National General Practice Accreditation (NGPA) scheme and National Safety and Quality Primary and Community Healthcare Standards (NSQPCHS), both of which are voluntary.

Issue to be addressed

The above context, especially the fact that accreditation against national standards is voluntary in primary care, means that clinical governance, risk management and quality improvement mechanisms may not be in place or performed consistently across the sector. This carries risks for understanding and trust between primary care professions. Absence of such a mechanism may also unnecessarily constrain scope of practice.

Recommendation 17

The Australian Government mandates participation by all primary care providers in an accreditation program under the applicable Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation schemes, or other relevant accreditation programs, i.e.:

- National Safety and Quality Primary and Community Healthcare Standards
- National General Practice Accreditation
- Quality Care Pharmacy Program (QCPP).

17.1 The Australian Government implements a program of capacity building for clinical governance, risk management and quality assurance across the primary care sector to be supported by Primary Health Networks (PHNs) or other appropriate bodies.

Mechanism to achieve change

A two-pronged approach would be needed to strengthen clinical governance in primary care.

1. Firstly, the Australian Government should mandate participation by practices in the relevant ACSQHC accreditation scheme (NGPA or NSQPCHS) or QCPP.
2. Secondly, a program of support for this change should be developed so that all primary care providers are supported to participate in the accreditation schemes.

Primary Health Networks (PHNs) could play a key role in supporting primary care providers to strengthen their approach to clinical governance. Support for PHNs or other appropriate bodies to take on this new capacity building role is proposed to form part of the program outlined in Recommendation 14.

Intended outcome of the recommendation

For consumers

Consumers will benefit from greater trust and confidence in their primary care providers. They can be better assured their health care team meets quality and safety standards. Health professionals are better supported and enabled to safely work at full scope of practice to better meet consumer care needs.

For the multidisciplinary care team

Primary care professionals will be better supported to meet clinical governance requirements, practice quality improvement, build trust and confidence across teams and health professions. This will better support multidisciplinary health care teams and professionals to work to full scope of practice and better meet consumer needs.

Prioritise reform in rural, remote and underserviced communities

Context

Multidisciplinary models of care are a known feature of rural and remote primary care teams. Rural and remote communities are more likely than metro areas to be affected by historical underservicing by primary care services. Because rural and remote primary care teams tend to operate in an environment of scarce workforce availability, they are likely to work closer to their full scope of practice and were frequently identified through this Review as sites of scope of practice innovation.

Issue to be addressed

Regional and remote primary care teams are subject to similar scope of practice barriers as the broader primary care workforce. The effects of scope of practice barriers on communities tend to be magnified due to workforce shortages and access barriers in rural and remote areas. These barriers may even result in rural and remote community members being unable to receive the care they need.

For these reasons, rural and remote regions present the greatest immediate opportunity to establish and spread health workforce innovation and reform. They simultaneously demonstrate the most significant adverse impacts of the absence of critical health reform, have more incentive to embrace reform, and display more of the essential cultural and leadership characteristics for reform to advance.

Recommendation 18

Governments commit to prioritise implementation of reforms in rural, remote and underserviced areas, and to engage with relevant organisations and stakeholders to collaboratively design implementation solutions specific to rural, remote and underserviced communities, commencing with:

A2 Strengthen the capability of the primary care workforce – design specific implementation pathways for a primary care workforce development program (Recommendation 2), including specific support mechanisms to enable students to travel and stay in rural and remote locations while completing education and training/placement.

B2 Independent, evidence-based support for health workforce innovation, access and productivity – commence the innovation assessment process with rural and remote workforce models (Recommendation 9).

C1 Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice, through introduction of a new blended payment and a transition payment (see Recommendation 10) which:

- Makes appropriate and equitable adjustments at the fundholder level for historical underutilisation of MBS and other primary care programs due to long-standing GP, nursing and allied health shortages (Recommendation 10.4).

    - Incentivises establishment and spread of innovative multidisciplinary models of care including rural generalists, nurse/allied health/ midwifery led clinics, and advanced remote service delivery models (Recommendation 10.4).
    - Design and implement an alternative patient registration model to ensure access to the broad-based risk adjusted blended payment for historically underserviced communities, prioritising rural and remote areas (Recommendation 10.6).
    - Implement the blended payment model in a staged program commencing with rural and remote regions (Modified Monash Model 5-7) and underserviced regional areas (Recommendation 10.8).
    - Implement the bundled payment for maternity care with a targeted rural and regional model (Recommendation 11).
- **C2** Direct referral pathways – commence implementation in rural and remote regions (Recommendation 12).
- **D2** Primary care system integration and support through Primary Health Networks (PHNs) – focus capability uplift in rural and remote PHNs to support the above targeted implementation efforts (Recommendation 14).

Mechanism to achieve change

The key mechanism for change will be a rural and remote-specific implementation approach across the relevant recommendation detailed above. For many of the recommendations, a rural and remote-specific implementation approach or delivery pathway will need to be established which addresses the specific considerations for rural and remote areas.

To achieve this, extensive engagement will be undertaken with relevant organisations and stakeholders to collaboratively design implementation solutions which meet the needs of rural and remote communities and retain flexibility for local nuances and context.

Intended outcome of the recommendation

For consumers

Consumers in rural and remote areas will benefit from the combined intent of reforms delivered in a manner which prioritises and responds appropriately to rural and remote context. From the sum total of reforms, consumers will be better able to access the primary care they need from multidisciplinary teams working to full scope of practice.

For the multidisciplinary care team

Multidisciplinary care teams will similarly benefit from the sum total of reforms delivered in a manner which prioritises rural and remote context and requirements. As a result, teams will experience fewer barriers to working together to full scope of practice and will be, overall, better supported by a system which recognises the unique and valuable contribution rural and remote providers make to primary care delivery and innovation.

1

Background

1. Background

The *Strengthening Medicare* Taskforce [4] began work in July 2022 to provide concrete recommendations to the Australian Government in relation to improving consumer access to primary care.

In December 2022, the *Strengthening Medicare Taskforce Report* outlined the *Strengthening Medicare* Taskforce's priority recommendations to improve primary care in the areas of:

- Increasing access to primary care
- Encouraging multidisciplinary, team-based care
- Modernising primary care
- Supporting change management and cultural change.

One of these areas was that the Australian Government work with States and Territories to review the barriers and enablers for all health professionals to work to their full scope of practice.

In April 2023, National Cabinet, which consists of the Prime Minister and First Ministers from all States and Territories, supported the Taskforce recommendations. In response, the 2023-24 Federal Budget included measures to respond to the recommendations including a scope of practice review to examine current models of primary care.

Professor Mark Cormack led this intensive, Independent Review. Titled 'Unleashing the Potential of our Health Workforce', the Scope of Practice Review (the Review) examined the benefits, risks, barriers and enablers to health professionals working to full scope of practice within multidisciplinary care teams in primary care. The Terms of Reference for the Review refer to the guiding principles of:

- Supporting innovation that improves access to care to meet community needs
- Better using technology to expand scopes of practice, to support greater productivity and improve quality of care
- Supporting health system productivity by encouraging more health professionals to work to the top of their scope of practice, where this is not currently occurring
- Identifying opportunities to progress reform in a consistent way, rather than through professional silos.

The Review was conducted in four phases between September 2023 and October 2024. The Review focused on the following health professions:

- General practitioners (GPs)
- Nurses, including nurse practitioners, registered nurses and enrolled nurses
- Pharmacists
- Midwives
- Allied health professionals
- Aboriginal and Torres Strait Islander Health Practitioners and Health Workers
- Paramedics.

The Review examined the following focus areas for opportunities and lessons learned:

- Legislation and regulation
- Education, training and collaboration
- Funding mechanisms
- Employer practices and work context
- Technology
- Leadership and culture.

In addition, examples were reviewed of conditions that have enabled multidisciplinary teams to work at their full scope of practice in delivering better care.

[4] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.

2

Primary care

2. Primary care

Primary care has been described by the World Health Organization as a model of care that supports first-contact, accessible, continuous, comprehensive, and coordinated person-focused care.[5] It is viewed as a key pillar in a health system to enable provision of health promotion, disease prevention, treatment, education, rehabilitation and support services throughout the life course. *Primary health care* is a whole-of-society approach to effectively organise and strengthen national health systems to bring services for health and wellbeing closer to communities comprising three components: integrated health services to meet people's health needs throughout their lives, addressing the broader determinants of health through multisectoral policy and action, and empowering individuals, families, and communities to take charge of their own health.[6]

In Australia, primary care generally refers to health care people seek first in their community, outside of a hospital. These primary care services include for example: general practices, ACCHOs, community pharmacies, many allied health services, nurse-led clinics, mental health services, drug and alcohol services, community health and community nursing services, maternal and child health services, sexual health services, urgent care clinics and oral health and dental services.

Primary care is provided in multiple ways, often by private businesses (e.g. GP clinics, community pharmacies, and allied health practices). In rural and remote regions, primary care may be delivered by a range of providers including State and Territory Governments via LHNs, non-government organisations such as the Royal Flying Doctor Services (RFDS), and remote area nurses. Comprehensive and culturally competent holistic primary care services are also delivered by ACCHOs which are initiated and operated by local First Nations communities.

PHNs that are independent government funded organisations, also coordinate, support and commission primary care programs and services. PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it.

Although the term 'primary care' may be considered to indicate general practice specifically, for the purposes of this report, this term includes the full breadth of health professionals who provide first contact care in the community.

The primary care workforce is diverse and includes a broad range of health professionals, technicians, assistants and support workers, as well as administrative staff with expertise in primary care services. Each group has distinctive workforce practices and distribution, often determined by specific work policies and funding models. This Review considered a range of health professions who work within these settings, as outlined in *Section 1 Background*.

[5] World Health Organization (n.d.) Primary care. Accessed 1 August 2024.
[6] Ibid.

3

The journey for this Review

3. The journey for this Review

Figure 2 Overview of the journey

Sources of evidence

The sources of evidence which informed this Review consisted of submissions, public consultation, a literature and evidence review, and a legislation and regulation review.

Public consultation

Public consultation was conducted over four phases (see Figure 2) and informed the development of two Issues Papers (alongside the literature and evidence review and legislation and regulation review) as summarised below.

Expert Advisory Committee

An **EAC** was convened at regular points throughout the Review to provide subject matter expertise, insights and advice. The EAC met for the first time in November 2023 and met in each of the Review phases. This Committee included representatives from many areas of the health workforce, education and training sector, universities and consumers. Each member provided a wealth of experience, knowledge, skills and perspectives in the area of innovative and multidisciplinary primary care. See *Appendix A* for EAC membership.

Phase 1

Phase 1 of the Review involved a **preliminary consultation** process between September and December 2023 to gather a wide set of views across the Review's full remit. More than 700 submissions in response to targeted questions on scope of practice were received, and consultation meetings were 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.

Phase 2

Issues Paper 1 was released on 23 January 2024. This first Issues Paper provided an overview of policy issues through a review of the evidence, submissions provided to the Review team and the Phase 1 consultation. Five themes were explored in this phase:

1. **Legislation and regulation** – where legislation or regulation authorise or inhibit health professionals in performing a particular activity within their scope of practice.
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.

Issues Paper 1 explored these themes and specific questions were posed for feedback on each theme and on areas that required further exploration.

Phase 2 consultation was undertaken between 23 January and 8 March 2024. The consultation process generated feedback from a range of perspectives on the emerging themes raised in Issues Paper 1. Consultations occurred via a public submissions portal, face-to-face workshops across Australia, virtual workshops and targeted stakeholder meetings. A total of 161 submissions were received via the portal and 86 via email. Consultations were attended by over 500 participants, across 19 face-to-face sessions and three targeted virtual sessions for consumers, and rural and remote stakeholders.

During Phase 2 consultations, stakeholders were asked to provide feedback regarding a range of opportunities for improvement developed in response to Issues Paper 1. 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 peoples and consumer perspectives.

Targeted consultation with a range of stakeholder groups was also undertaken throughout March 2024. This consisted of feedback of findings from Phase 2 consultation and testing of emerging themes.

Phase 3

Issues Paper 2 was released on 16 April 2024. The feedback received during Phase 2 consultations was synthesised with other available evidence to produce this second Issues Paper. Issues Paper 2 distilled the themes from five to three:

1. Workforce design, development and planning
2. Legislation and regulation
3. Funding and payment policy.

It explored specific options for policy and system reform available under each theme to address identified barriers associated with health professionals working to full scope of practice.

Phase 3 consultation was undertaken throughout June 2024. The consultation process generated feedback from a range of perspectives on the emerging themes raised in Issues Paper 2. Consultations occurred via a public submissions portal, face-to-face workshops across Australia, virtual workshops and targeted stakeholder meetings. A total of 120 submissions were received via the portal and 69 via email. Consultations were attended by over 225 participants, across seven face-to-face sessions and four targeted virtual sessions for First Nations peoples, consumer, and rural and remote stakeholders.

Targeted consultation with a range of stakeholder groups, including State, Territory and Australian Government officials was also undertaken throughout the consultation process to test specific issues, questions and emerging areas of consensus and divergence.

Phase 4

This phase of the Review drew together all the evidence from literature and consultations to present the draft Final Report and Implementation Plan. Targeted consultation on the draft was undertaken throughout August and September, with a view to fact checking. The final Review Report was prepared and submitted to the Minister for Health and Aged Care in October 2024.

Literature and evidence review

A literature and evidence 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 Phase 1, and described in Phase 2 (legislation and regulation, employer practices and settings, education and training, funding and technology), the literature and evidence review considered four key questions:

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

Literature was considered for the professions included in the scope of this Review (Aboriginal and Torres Strait Islander Health Practitioners and 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 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 above 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 [7] software. In total 1,352 relevant studies were identified, 1,206 from the published literature and 146 from grey literature screening.

[7] Covidence Veritas Health Innovation Ltd. Covidence. Accessed 1 May 2024.

International best practice case studies were also explored under the focus areas listed using a realist perspective, which was selected to enable in-depth exploration of the impact of the political, social, health care and other contexts on scope of practice changes. A realist perspective is based on the premise that for any outcome, in this case health professional scope of practice, there are one or more causal processes (mechanisms) that are relevant in certain contexts: Context-Mechanism-Outcome. This included consideration of the 'current status' of full scope of practice by health professional groups and areas of clinical practice; international and national exemplar case studies; opportunities for consideration for full scope of practice within Australia; and barriers, risks, policy and regulatory settings which would need to be addressed to implement and sustain the value and benefits of full scope of practice.

Legislation and regulation review

Given the importance of legislation and regulation in shaping and subsequently framing scope of practice, a review of the legislation and regulation identified as impacting practice scopes, either directly or indirectly was undertaken. The objective of this Review was to identify the material barriers in the existing legislative environment across Australia to health professionals working to full scope of practice. The review specifically sought to identify a shortlist of legislative and 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. The elements of the review were:

1. A longlist of all legislative and regulatory subjects which directly or indirectly limit primary care scope of practice (either purporting to limit scope or having a practical impact on scope of practice) was identified. This was tested 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*).[8]
2. A high-level review of selected areas of legislation was undertaken to ascertain their likely impact on scope: *Health Practitioner Regulation National Law Act 2009* (Health Practitioner National Law, as applied in each State and Territory), drugs and poisons legislation in each jurisdiction, mental health legislation in each jurisdiction, and the *Health Insurance Act 1973* (Cth).
3. Targeted mapping and analysis were then undertaken of the following areas of law, which were identified to have the most substantial impacts out of the Pareto group identified: The *Health Insurance Act 1973* (Cth) and associated legislative instruments; and State and Territory drugs and poisons legislation and regulation.
4. Based on the findings of the targeted mapping and analysis, detailed mapping was undertaken of all State and Territory drugs and poisons legislation to indicate areas of inconsistency and to ascertain how references to the National Law may have a (practically) limiting impact on scope of practice.
5. Also based on the targeted mapping and analysis, a targeted review of the *Health Insurance Act 1973* (Cth) and associated legislative instruments (regulations and determinations) was conducted to validate hypotheses developed through analysis of Phase 2 evidence. This review had a particular focus on limitations on which health professionals can refer patients to other health professionals or request pathology or imaging for patients under the MBS; the ability of nurses to deliver mental health care services in the community under the MBS; and inconsistencies in the fees prescribed for MBS services undertaken by different health professionals.

Consumer voices

Ensuring consumers benefit from improved primary care, delivered by highly functioning multidisciplinary care teams, is a core aim of this Review. Throughout, the Review has sought the views and advice of consumer representatives about both specific reform proposals and how the direction of reform is understood to affect communities across Australia.

In addition to consumer participation in stakeholder round tables, targeted consultation was undertaken with consumer representatives delivered in partnership with Consumers Health Forum of Australia (CHF). Online consultations were held during both Phases 2 and 3 to enable consumer representatives (recruited through CHF) to provide their views about Issues Papers 1 and 2, respectively. Consumers were also invited to participate in the public surveys released during Phases 2 and 3.

[8] NSW Government (n.d.) Pareto charts & 80-20 Rule. Accessed 20 September 2024.

First Nations voices

Targeted consultation with the First Nations health sector was undertaken to inform the proposals for reform, in addition to representatives of the First Nations health sector at stakeholder round tables in Phases 2 and 3. Online consultation was held with First Nations health sector representatives during Phases 2 and 3, in a dedicated consultation format delivered by an experienced First Nations facilitator. These consultations sought to foster discussion and understand participants' perspectives about the themes explored in Issues Paper 1 and the reform options put forward in Issues Paper 2, respectively.

A clear message was heard throughout these conversations that there is a need to better respect and recognise the value and expertise of First Nations health professionals in delivering culturally safe models of care. Meeting this need was an ongoing focus throughout this Review and must be at the core of all implementation efforts.

Rural and remote voices

Targeted consultation was undertaken with stakeholders representing rural and remote primary care. Online consultation was held with rural and remote primary care during Phases 2 and 3, delivered in partnership with the National Rural Health Alliance. These consultations sought to understand rural and remote considerations for themes explored in Issues Paper 1 and the reform options in Issues Paper 2, respectively. During Phase 3, an additional in-person consultation was held with rural and remote stakeholders, coinciding with a National Rural Health Alliance Council meeting, which sought further views in relation to Issues Paper 2 and the implementation of the reform options contained within.

4

The case for change

4. The case for change

Australia's primary care sector is central to the nation's universal health care system and is supported by a skilled and dedicated primary care workforce. Primary care is often the first and most regular point of contact consumers have with the health system.[9, 10] More broadly, primary health care encompasses health service integration to meet population need, the use of policy and action across sectors to address the health determinants, and empowering individuals, families and communities to take charge of their health.[11]

The primary care workforce provides care across a variety of settings including general practice, community health clinics, Aboriginal Community Controlled Health Services, community pharmacies, nursing and midwifery services, including nurse-led clinics, oral health and dental services, mental health services, maternal and child health services, urgent care clinics and allied health services such as those offered by physiotherapists, psychologists, dietitians and speech pathologists. Within the broader health system, primary care provides a range of services and intersects with several other health and social sectors to provide care. Across this diverse service landscape, there is a critical need to effectively co-ordinate care and maintain continuity of care, particularly at points of transition between care providers and/or health sectors.

Medicare has provided universal health coverage, in its present form, for all Australians since 1984 and has contributed over $488 billion in benefits since its introduction.[12] Today, Medicare faces a range of pressures including Australia's ageing population and the need to provide care for a greater proportion of the population living with complex health needs. To ensure the system continues to support the population to access affordable health care, the Australian Government is undertaking work to strengthen Medicare.

The vision for *Strengthening Medicare*[13] describes a primary care system with four essential features, outlined below.

Increasing access to primary care

All Australians are supported to be healthy and well through access to equitable, affordable, person-centred primary care services, regardless of where they live and when they need care, with financing that supports sustainable primary care, and a system that is simple and easy to navigate for people and their health care providers.

Encouraging multidisciplinary team-based care

Coordinated multidisciplinary teams of health care providers work to their full scope of practice to provide quality person-centred continuity of care, including prevention and early intervention; and primary care is incentivised to improve population health, work with other parts of the health and care systems, under appropriate clinical governance, to reduce fragmentation and duplication and deliver better health outcomes.

Modernising primary care

Data and digital technology are better used to inform value-based care, safely share critical patient information to support better diagnosis and health care management, empower people to participate in their own health care, and drive insights for planning, resourcing, and continuous quality improvement.

Supporting change management and culture change

The primary care sector is well supported to embrace organisational and cultural change, and to support innovation; consumers are empowered to have a voice in the design of services to ensure they meet people's needs, particularly for disadvantaged groups; and all levels of government work together to ensure the benefits of reform are optimised.

[9] World Health Organization (2020) Global strategy on human resources for health: Workforce 2030. Accessed 15 September 2024.
[10] Australian Government Department of Health and Aged Care (2023) About primary care. Accessed 1 August 2024.
[11] World Health Organization (n.d.) Primary care. Accessed 1 August 2024.
[12] Australian Government Department of Health and Aged Care (2024) The history of Medicare. Accessed 22 July 2024.
[13] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.

By endorsing the *Strengthening Medicare* Taskforce measures, National Cabinet agreed to pursue the above vision (April 2023). This has been progressed through a range of measures led by the Australian Government, and a complementary program of work led by States and Territories and other key stakeholders.

This Review has focused on analysing and responding to the second feature of the primary care vision i.e. *"coordinated multidisciplinary teams of health professionals work to their full scope of practice to provide quality, person-centred continuity of care"* [page 3].[14] This reflects the essential workforce design, capability and intrinsic models of care that will deliver the overarching vision of increasing access to primary care. Ultimately, the vision will be enabled through modernising the system and supporting the change effort required for its achievement.

In practical terms, the Review has set about to analyse and make recommendations to address scope of practice issues which could contribute to a misalignment between the present-day reality for consumers and health professionals and the new policy vision for Australia's primary care system.

The following provides a summary of the Review phases and findings. Further detail is provided in *Appendix B*.

The current state

Review Phase 1 (September - December 2023)

Assessment and analysis of the current state was progressively built over the first three phases of the Review. Phase 1 sought to identify the full range of benefits, risks, barriers and enablers associated with *"co-ordinated multidisciplinary teams of health care professionals working to their full scope of practice to provide quality person-centred continuity of care" as described in the Strengthening Medicare Taskforce report.*[15]

The broad range of evidence canvassed in Phase 1 gave rise to a high-level view that there are significant and increasing gaps between the *Strengthening Medicare* policy vision and the present day reality. These gaps are understood to be:

- Linked directly to unnecessarily restrictive, unresponsive and entrenched policy settings at the Commonwealth, State and Territory levels
- Founded in deeply embedded professional and workplace culture, custom and practice that disproportionately affects some professions
- Adversely impacting on consumer access to quality primary care with a disproportional impact on people living in rural, remote and underserviced areas; First Nations peoples; marginalised and lower socioeconomic population groups
- Contributing to persistent suboptimal productivity of a highly skilled, chronically undersupplied and maldistributed health workforce
- Requiring a comprehensive program of co-ordinated, resourced reform spanning the short, medium and long term.

During this first phase of consultation, a range of benefits, risks, barriers and enablers were identified as impacting primary care health professionals' scope of practice. Stakeholders saw a major benefit in enabling the primary care team to achieve its full potential by providing best practice, consumer-focused care. While many stakeholders saw a greater risk in not allowing health professionals to work to their full scope of practice, others identified potential risks associated with the quality of care provided to the consumer and the consumer experience.

[14] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.
[15] Ibid.

Poor quality of care, and more specifically poor consumer safety, was raised as a potential consequence should health professionals work beyond their competence, while consumer confusion about what they can expect from a health professional was identified as negatively impacting their care experience.

During Phase 1, the existence of significant cultural barriers that negatively impact interprofessional trust and the function of the multidisciplinary team were highlighted. Cultural barriers were described as entrenched views that significantly impact health professional practice, often resulting from poor recognition of, and respect for, professional skills. The significance of addressing entrenched cultural views that impact practice scope was highlighted through this and all further rounds of consultation.

Additional barriers, many of which were noted to be potential enablers if successfully addressed, included a range of issues that congregated around the following core areas:

- Funding and payment mechanisms, including the over-reliance on the fee-for-service funding model
- Significant inconsistencies in legislation and regulation across jurisdictions, including drugs and poisons legislation
- Inconsistencies in access to, and recognition of, education and training to prepare primary care health professionals.

Effective technology was viewed as an enabler of the multidisciplinary team function yet identified as lacking in many jurisdictions.

Further detail of the findings of Phase 1 of the Review are provided in *Appendix B*.

Review Phase 2 (January – March 2024)

In Phase 2, the preliminary findings were consolidated to produce the first Issues Paper released for public consultation. Issues Paper 1 set out the five key themes that had emerged from a synthesis of the evidence gathered in Phase 1 via consultation and the literature and evidence review, as described in *Section 3 The journey for this Review*. For each theme, the challenges, opportunities for improvement and potential benefits were presented in Issues Paper 1. The themes, summarised below and further described in *Appendix B,* were used as an organising framework for potential reform opportunities which were the focus of further consultation.

Legislation and regulation

Legislation and regulation were identified as significant elements of the authorising environment that either enabled health professionals to work to their full scope of practice or inhibited this outcome. There was frequent acknowledgement that the inflexibility and poor responsiveness of legislation and regulation functionally impacted health professional scope. In addition, inconsistencies across jurisdictions were identified and viewed as a barrier to health professional scope of practice and to consumer access to care. Potential areas for reform proposed during this phase of consultation included:

- Harmonising drugs and poisons legislation
- Introducing risk-based and activity-based regulatory processes
- Streamlining endorsement processes
- Reviewing the authorising environment for health professionals outside the NRAS.

Employer practices and settings

Employer practices were identified as impacting health professional scope of practice through a range of mechanisms, including inconsistent recognition of health professional skills and capabilities which can impede health professionals from working across health settings and/or sectors, poor availability of roles that reflect full scope and a lack of remuneration commensurate with skills and capabilities. Professional culture and leadership were highlighted as having a significant impact on employer practices and identified as instrumental to reforms in this area. The following potential areas for reform were proposed:

- Establishing more consistent approaches to recognition of qualifications and competencies across settings
- Establishing models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers
- Strengthening clinical governance mechanisms in primary care settings.

Education and training

Health professionals reported challenges in accessing and completing education and training to support their scope of practice and reiterated the significant impact that poor recognition of their skills and capabilities has on their practice scope. Developing the primary care workforce through quality student education and training was noted to be affected by student-borne costs to complete practical training and poor recognition of the important role of student supervision during workplace-based training. The following potential areas for reform were proposed:

- Establishing mechanisms that support primary care experiences in pre-professional entry education and training programs
- Establishing greater clarity about post-professional entry learning
- Establishing a nationally consistent approach to promoting and implementing common interprofessional competencies
- Promoting multi-professional learning
- Ensuring ongoing education and training are accessible.

Funding policy

Alongside legislation and regulation, funding policy was acknowledged as a core element of the authorising environment. Reform in this area was identified as having the potential to significantly impact health professional scope of practice. Furthermore, funding reforms were considered essential to enable successful reforms in other areas. Consultation identified overarching support for all proposed policy solutions and for funding reforms that supported the multidisciplinary team. The following areas for reform were proposed during this round of consultation:

- Using block, bundled and blended funding to deliver care flexibly
- Establishing funding and payment types which enable working as multidisciplinary care teams
- Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules
- Single payment rate for like services with a common scope (i.e. a single MBS rate for a particular activity).

Technology

Digital strategies were considered important facilitators of health professional practice but were noted to not specifically enable full scope of practice. Inconsistent access to digital health systems, including patient data systems, were identified across professions. Potential areas for reform included:

- Establishing access to real-time patient information
- Introducing platforms for secure messaging and digital referrals
- Using decision support software
- Mandating participation in a multidisciplinary care team for primary care providers.

During Phase 2 consultation, several factors were identified as essential to successful reform across all policy areas. In summary, these factors include:

Multidisciplinary care

In addition to enabling individual health professionals to work to their full scope of practice, there was a common view that it was essential to specifically enable the collective multidisciplinary team to achieve its full potential. It was noted that, currently, there are barriers to achieving this. Central to effective multidisciplinary team care was the need to build the team around consumer and community need, rather than specific professions.

“Can we stop talking about maldistribution of health professionals, and instead think about competencies needed for an area and grow from there? We’re never going to get perfectly equal distribution in terms of health professional roles, so let’s stop talking about it.”

Consultation participant

“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.”

Consultation participant, rural and remote perspective

Establishing multidisciplinary care that is responsive to, and built around, the needs of the consumer, family and community, was viewed as better primary care, and a supported aim of reforms. Figure 3 depicts this aim.

Stakeholders discussed the intersections between the primary care system and adjacent systems, such as hospital, aged care and disability systems, many of whom are serviced by the same workforces. Care pathways between these systems were raised as being important to consider in terms of continuity of care.

Figure 3 The multidisciplinary care team

Leadership, culture and governance

Leadership, culture and governance were described as potentially the most critical enabler (or conversely, barrier) to health professionals working to full scope of practice. Many felt that interprofessional trust could be improved both between health professionals and between leaders, where organisational culture is shaped.

All policy areas were identified as potentially impacting, and being impacted by, leadership, culture and governance, making these critical influencers for reform. An example repeatedly raised was that of self-regulated health professions that can be perceived as less competent or delivering less valuable care because of poor understanding and culture.

Evidence review summary

The literature and evidence review examined full scope of practice across individual professions, representing multiple countries and health systems. Four key findings were identified, related to the quintuple aim of health care (improved patient experience, better outcomes, lower costs, improved clinician wellbeing and improved health equity) where health professionals are enabled to work at full scope of practice.

- Improved access through longer consultations, more information sharing, and appropriate care utilisation across health professions.
- Equal or better outcomes across a range of clinical areas, including chronic disease management and mental health, when health professionals are enabled and supported to work to full scope of practice.
- Improved efficiency and potential cost savings, with some evidence of lower total costs and prevention of unnecessary services.
- Improved access in rural, remote and medically underserved areas, with short-term improvements in workforce distribution.

At the conclusion of Phase 2, the evidence collected, and consultation discussions clearly described a range of challenges impacting the ability of primary care health professionals to work to their full scope of practice. There was consensus that the time had come to change primary care for the better.

"Our health care provision is brilliant, but it is overwhelmed which creates risk, and [risks to] safety. We need to think differently and maybe what we are currently doing and who is delivering all care is in fact not the right person for all care anymore."

Consultation participant, health professional perspective

Progressing the case for change

The sum of the above evidence clearly articulates areas in need of reform to create the primary care system which matches the vision of *Strengthening Medicare*.

Review Phase 3 (April – June 2024)

Drawing together the findings of previous consultations, the literature and evidence review, and the review of legislation and regulation, a second Issues Paper was developed. The five original themes were distilled to three:

- Workforce design, development and planning (combining the previous employer practices and settings theme with the education and training theme)
- Legislation and regulation
- Funding and payment policy.

Given the considerable national work currently underway elsewhere to address digital reforms, the Technology theme was removed as a standalone theme, with digital health considerations addressed as relevant under the themes above.

Issues Paper 2 presented eight options for reform, as summarised in Table 1.

Table 1 Proposed Issues Paper 2 policy reform options

Issue	Proposed Option for Reform
Workforce design, development and planning	
Poor recognition of primary care health professional skills and capabilities impedes interprofessional trust, multidisciplinary team-based care and effective health workforce planning. Limited focus on primary care in the professional entry curriculum and poor support for health professionals impedes the ability to develop skills specifically required for primary care. Poor support for early career health professionals and inconsistencies in post-professional entry education and training impede health professionals' ability to develop primary care skills post-professional entry.	1. **National Skills and Capability Framework & Matrix** to improve understanding of health professional skills and capabilities and establish a basis for workforce planning. 2. **Develop primary care capability** to equip health professionals to practise effectively to full scope of practice. 3. **Early career and ongoing professional development, includes multi-professional learning and practice** to maintain primary care skills and support the team to effectively work together.
Legislation and regulation	
Highly restrictive regulation indirectly limits scope of practice. Legislation and regulation are not adequately responsive to emerging evidence or innovation in scope of practice. Inconsistency between State and Territory drugs and poisons legislation impacts consistency of scope of practice between jurisdictions.	4. **Risk-based approach to regulating scope of practice to complement protection of title approach** to enable health professionals to more consistently work to full scope of practice. 5. **Independent, evidence-based assessment of innovation and change in health workforce models** to inform legislation and regulation and enable contemporary best practice. 6. **Harmonised drugs and poisons regulation to support a dynamic health system** by providing consistency and clarity between States and Territories.
Funding and payment policy	
Primary care funding and payment models do not support health professionals to work at full scope in multidisciplinary care teams. MBS payment rules and inadequate digital infrastructure restrict health professionals' ability to make direct referrals within their scope.	7. **Funding and payment models that incentivise multidisciplinary care teams** working to full scope of practice to support the primary care team. 8. **Direct referral pathways supported by technology** that enables health professionals to make referrals within their scope and to improve access to care for consumers.

The proposed areas for reform were noted to be interdependent, with many relying on progress in other areas for success. For example, many reform options rely on parallel changes to funding models. Similarly, across all areas, leadership, culture and clinical governance were identified as critical supports. A culture of inclusivity and trust was considered essential to improved team-based care, whereas one of the professional siloes was considered a barrier to this outcome. Strong leadership, supported by a clear vision for, and commitment to, reform was seen as foundational to all primary care reforms. Stakeholders identified the essential nature of quality assurance mechanisms that systematically review, and seek to improve, care across all areas of reform.

The Review team undertook an extensive program of consultation and analysis of submissions received in response to Issues Paper 2, including broad interrogation of the potential reforms. Face-to-face and virtual consultations were undertaken in conjunction with a detailed analysis of written submissions and responses to an online survey, all of which were synthesised with the literature and evidence review findings. This phase of consultation and analysis shaped the development of a program of consensus-based reforms for consideration by government.

The reforms presented in this report reflect the findings of the three phases of the Review and are carefully crafted to collectively contribute to significant positive change in the delivery of primary care.

Learning from First Nations voices

The need to better respect and recognise the value and expertise of First Nations health professionals in delivering culturally safe models of care was strongly heard across the Review. However, cultural safety should not be understood as being the domain of the Aboriginal and Torres Strait Islander health workforce only, but the responsibility of everyone. The specific impacts of racism in restricting the scope of practice of individual First Nations health professionals, as well as the Aboriginal and Torres Strait Islander health workforce, were specifically called out. These compound with other cultural and leadership factors to create barriers for First Nations peoples working in the primary care workforce, with serious impacts for First Nations peoples who need to access primary care.

The ACCHO model is one of the key examples of multidisciplinary team-based care which is designed and delivered to meet the needs of First Nations communities and families. Many people consulted over the course of this Review, from both ACCHO and mainstream sectors, raised the ACCHO model as an exemplar blueprint for reform across the broader primary care sector. Specific exemplars combine a holistic model of care with an innovative multidisciplinary team structure which equalises the roles of all team members (see the *Case study: Institute for Urban Indigenous Health*). In learning from these models, it is important to acknowledge the expertise of those who have pioneered and developed this innovation over time. It is also important to understand that attempts to scale up these models of care and apply them outside the place and context in which they are developed are unlikely to result in intended outcomes in all settings and may result in harm to consumers and health professionals alike. A meaningful and ongoing focus on cultural safety is a critical success factor across all efforts to apply learnings from the ACCHO model.

Case study: Institute for Urban Indigenous Health

Southeast Queensland's Institute for Urban Indigenous Health (IUIH) has developed a revised System of Care, inspired by the Native American Nuka model in Alaska for a First Nations context. The IUIH System of Care 2 (ISoC2) utilises Pod Teams consisting of a health and wellbeing worker, receptionist, nurse, GP and social health care coordinator, with clients and families accessing continuity of relational care through their chosen Pod Team. Clients engage with different members of the Pod Team at different times depending on their needs, and the team works in a non-hierarchical and collaborative way which recognises and values the contributions all team members make in providing care.

The Nuka model, in its original context, has been evaluated to improve consumer outcomes, hospital use, and consumer and workforce satisfaction. The ISoC2 model has been demonstrated to improve consumer experience of care , continuity of care and improved access to the Aboriginal and Torres Strait Islander Health Workers and Health Practitioners with research into impact on outcomes currently underway.

Centring the consumer

At every stage of this Review, the importance of consumer involvement in the successful implementation of reform was emphasised. Ongoing participation by consumers from the design phase onwards will be important to ensure the reform proposals continue to deliver on their intended benefits for consumers. This Review recommends that a participatory process is embedded in the implementation of all recommendations.

In addition, this Review recognises that consumers are a core participant in the multidisciplinary care team, and it is important that all health professionals understand and value their involvement in their own care. Governments will be tasked with producing and broadcasting materials which clearly communicate what the reforms driven by this Review will mean for consumers, and these communications efforts are also needed at the individual service level between consumers and their primary care team. In this way, consumers will be supported to develop a clear understanding of the reforms, for these to reach their full potential in strengthening primary care.

Review Phase 4

A series of high-level findings have been distilled from the information gathered during the first three phases of the Review, as presented above. The findings characterise the current state of primary care in Australia, which can be summarised as follows:

Scope of practice is commonly restricted. Most health professions working in the primary care sector, including GPs, face some restrictions or barriers to working to their full scope of practice. These impediments are typically unrelated to their competence, qualification/s and professional accountability.

Awareness of health professional scope of practice is limited. Consumers and health professionals have a surprisingly poor understanding of the skills, capabilities, competence and scope of practice of members of the primary care team.

Preparation of, and support for, health professionals to practise in primary care is limited, especially when compared to the public hospital sector. Learning about primary care during pre-qualification programs is limited for some health professions, resulting in challenges attracting the primary care workforce. Support to remain, and develop skills, in primary care are limited, resulting in challenges in retaining the primary care workforce. Support for multidisciplinary teams is limited in primary care.

There are opportunities to improve health professional regulation. The NRAS is a mature, generally enabling professional regulation scheme, which is well regarded and trusted by its participants and the system more broadly. Opportunities exist to strengthen and standardise regulatory approaches to address specific legislative and regulatory issues which materially impact scope of practice.

Other legislative and regulatory settings restrict scope of practice in primary care. Outside the NRAS, legislative and regulatory settings have a significant and restrictive impact on health professionals working to their full scope of practice. This extends well beyond the NRAS.

Funding and payment policy settings restrict scope of practice in primary care. Funding and payment mechanisms (more than quantum) impede health professionals from working to full scope of practice and from working as part of a multidisciplinary team. Health professionals practising and remunerated via a predominately fee-for-service payment system face the most significant barriers to working to full scope of practice and as part of a multidisciplinary team; those practising and remunerated in a non-fee-for-service payment system (e.g., block, blended, bundled, salaried) face the least barriers to working to full scope of practice and as part of a multidisciplinary team.

Clinical governance and risk management in primary care are supported differently to those in the hospital sector. Structures, infrastructure and mechanisms to support and enable effective clinical governance and risk management in the primary care sector are variable, more basic, less resourced and generally voluntary when compared to that which applies in the hospital sector.

Culture and leadership are the most critical dependencies for achieving change in primary care. Reform proposals will not be achievable without an accompanying cultural change at system, profession, organisation and individual levels.

Rural and remote settings provide the greatest opportunity for more immediate and enduring positive change which support full scope of practice in a multidisciplinary context.

Many examples are available in Australia of better practice. Examples of effective, team-based care provided by health professionals working to their full scope of practice include:

- ACCHOs, including those that integrate community pharmacists within multidisciplinary teams to improve chronic disease management [16]
- Rural and remote multidisciplinary health services, e.g., rural generalist models
- Community health services that target higher risk, lower socioeconomic groups, e.g., the Victorian Community Health Service model [17]
- Innovative general practice models that employ, support and/or provide a range of multidisciplinary services and optimise the use of allied health professionals, primary health care nurses and pharmacists who work in general practice.

These features of primary care have a range of impacts, which include:

Restricted consumer access to optimal care, particularly for consumers living in regional and remote areas, where a health professional may be available, but not authorised or enabled, through legislation, regulation and/or funding arrangements, to provide care that falls within their scope.

Reduced opportunity for multidisciplinary care. Barriers restrict health professionals from working collaboratively as a multidisciplinary team and reinforce professional siloes.

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 an inability to work to full scope identified as a strong influence on health professionals choosing to leave the health workforce.

Inadequate preparation for practise in primary care due to limited practical experience in professional entry education and training programs and opportunities to maintain and develop skills as early career professionals.

Exclusion from NRAS for self-regulated health professions, which provides significant barriers to working to full scope of practice.

[16] Smith D, Couzos, S., Tremlett, M., Loller, H., Stephens, M., Nugent, A., Vaughan, F., Hendrie, D., Buttner, P., Biros, E. (2020) Integrating pharmacists within Aboriginal Community Controlled Health Services to improve chronic disease management (IPAC) project. Accessed 31 July 2024.
[17] Victoria State Government (2024) Community health services. Accessed 31 July 2024.

Boosting retention in primary care

Maximising retention of the existing skilled primary care workforce is critically important to ensure continued access to quality primary care. A wide range of factors influence primary care professional exit rates, not all of which are amenable to policy measures. However, evidence points to the fact that being valued and recognised for professional skills, capability and contribution, including being able to work to full scope of practice, are factors which positively influence retention of health professionals, and thus enhance continuity of care for consumers.

This impact is highlighted by health workforce data[18] (see Table 2) which indicates the rate of individuals leaving their respective profession, i.e. permanent exits, is highest for Aboriginal and Torres Strait Islander Health Professionals, midwives, paramedics, nurses and pharmacists, all of whom have been highlighted by this Review as experiencing significant barriers to working to their full scope of practice. If these professions' exit rates were equivalent to that of medical practitioners (representing the lowest exit rate amongst health professions for whom data was available), thousands of health professionals would cumulatively be retained in the health workforce. Acknowledging that exit rates are driven by numerous personal and structural factors, enabling health professionals to work to full scope of practice remains an important policy lever to strengthen retention to the extent possible.

[18] Source: Health Workforce Data provided by the Department of Health and Aged Care. Note that data is provided for whole of workforce, not limited to primary care professionals, and is applied here as being illustrative of broader sector trends which impact primary care.

Table 2 Health workforce retention rates 2023[19]

	Total No. practitioners	Exit rate % (mean)[20]	Actual exits	Exits at lowest rate[21]	Excess exits above lowest rate
Medical Practitioners	116,042	4.7	5,113	5113	0
Chiropractors	5,553	4.9	272	261	11
Dental Practitioners - Dentists	17,654	5	839	830	9
Optometrists	6,084	5.1	310	286	24
Podiatrists	5,671	5.8	300	267	33
Medical Radiation Practitioners - Nuclear Medicine	1,206	5.9	61	57	4
Osteopaths	3,087	5.9	182	145	37
Medical Radiation Practitioners - Diagnostic Radiology	13,652	6.4	896	642	254
Medical Radiation Practitioners - Radiation Therapy	2,521	6.4	155	118	37
Dental Practitioners - Other	5,907	7.2	419	278	141
Psychologists	33,034	7.3	2,336	1553	783
Physiotherapists	34,791	7.4	2,524	1635	889
Chinese Medicine Practitioners	4,051	7.8	307	190	117
Occupational Therapists	25,431	8	2,047	1195	852
Pharmacists	27,807	8.7	2,334	1307	1027
Nurses	370,338	9	39,073	17406	21,667
Paramedics	21,702	9.7	2,925	1020	1,905
Midwives	22,309	10.8	3,081	1049	2,032
Aboriginal and Torres Strait Islander Health Practitioners	659	21.4	127	31	96
Total workforce	**717,500**		**Total excess exits above lowest rate**		**29,918**

[19] Source: Health Workforce Data provided by the Department of Health and Aged Care. Note that data is provided for whole of workforce, not limited to primary care professionals, and is applied here as being illustrative of broader sector trends which impact primary care.
[20] An exit rate (mean) is calculated for each workforce, which is the mean annual rate of permanent exits since the commencement of the NRAS in 2010.
[21] Calculates a hypothetical number of exits in 2023 for each practitioner group which assumes each group's exits are at the same rate as lowest rate (Medical Practitioners, 4.7%) i.e. exits at lowest rate.

Broader review landscape

This work has been undertaken within the context of a range of other health reform projects. Many of these are focused on strengthening the capability of the health workforce, improving workforce planning and sustainability, and exploring new models of care. For example, national workforce strategies are currently in development or underway to support the allied health [22], maternity [23], medical,[24] and nursing workforces. [25] Achieving nationally consistent scopes of practice for the Aboriginal and Torres Strait Islander health workforce is a focus of the National Association of the Aboriginal and Torres Strait Islander Health Workers and Practitioners and the National Aboriginal and Torres Strait Islander Health Protection Committee, with work in progress to achieve this aim. [26] The Nurse Practitioner Workforce Plan was launched in 2023 and will improve the accessibility of this workforce over a 10-year period. [27] A review of prescribing by nurse practitioners and endorsed midwives is currently being undertaken while exploration of the introduction of prescribing for registered nurses continues. [28] The Ahpra Accreditation Committee is working to achieve greater consistency in the delivery of health professional education and training programs through a range of ventures. [29] The Committee has a strong commitment to advancing education focused on cultural safety and interprofessional collaboration and strengthening accreditation processes.

Current work will add to recently completed reviews that impact health professional scope of practice. These include reviews focused on existing funding arrangements (the current reviews of General Practice incentives [30] and MBS Allied Health Chronic Disease Management Services [31]), health professional regulation (the current Independent review of complexity in the NRAS,[32] the completed Kruk Review of overseas health practitioner regulatory settings [33] and the Snowball Review of governance of the NRAS [34] and accreditation systems within the NRAS (the Woods Independent Review of accreditation systems within the NRAS for health professions [35] and to plan for the digital needs of the health system into the future (National Digital Health Strategy 2023-2028 [36] and Strategy Development Roadmap,[37] Digital Health Blueprint 2023-2033 and Action Plan [38])). These reviews sit alongside the mid-term review of the National Health Reform Agenda. [39]

Directions for reform

The full details of the proposed reforms, and 18 recommendations attached to these reforms, are provided in *Section 5. Proposals for reform*. In summary, the reforms focus on removing barriers that impede health professionals from practising to their full scope and those that prevent multidisciplinary teams from providing the best collaborative care for consumers. Mechanisms that recognise the skills and capabilities of all primary care providers are included to enable the best available care provided by the most skilled member of the team, and ultimately deliver the best outcome for consumers and community.

An overview of reforms and recommendations is provided below in Figure 4.

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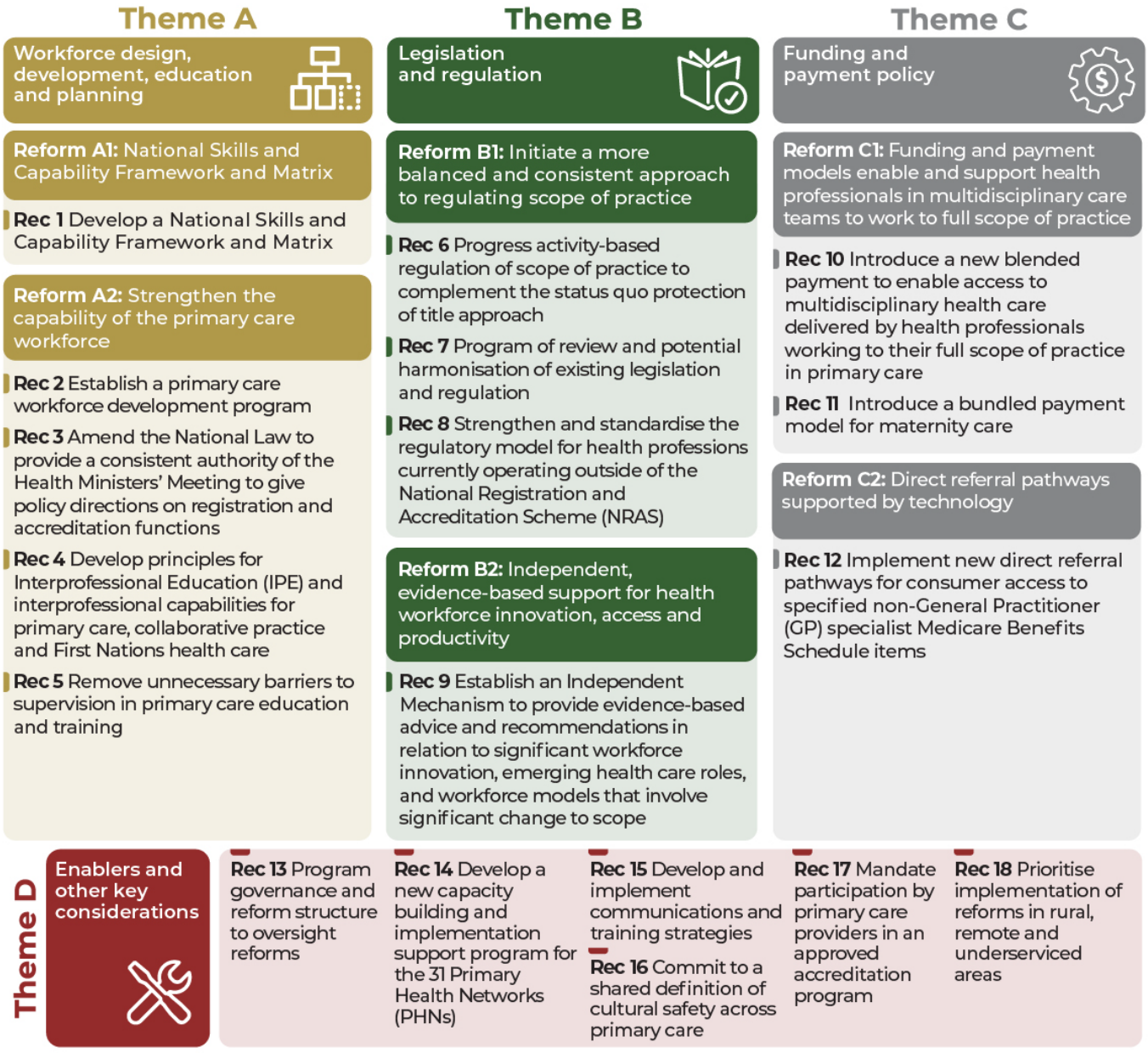
[22] Australian Government Department of Health and Aged Care (2024) National Allied Health Workforce Strategy. Accessed 15 September 2024.
[23] Australian Government Department of Health (2019) Australia's Future Health Workforce Report – Midwives. Accessed 22 July 2024.
[24] Australian Government Department of Health and Aged Care (2022) National Medical Workforce Strategy 2021–2031. Accessed 1 October 2024.
[25] Australian Government Department of Health and Aged Care (2024) National Nursing Workforce Strategy. Accessed 17 July 2024.
[26] Australian Government Department of Health (2022) National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031. Canberra, Commonwealth of Australia. Accessed 18 July 2024.
[27] Australian Government Department of Health and Aged Care (2023) Nurse Practitioner Workforce Plan. Accessed 1 August 2024.
[28] Australian Government Department of Health and Aged Care (n.d.) Nurse practitioner and midwife PBS prescribing consultation survey. Accessed 1 October 2024.
[29] Ahpra & National Boards (2023) Accreditation Committee Annual Report 2022-23. Accessed 15 September 2024.
[30] Australian Government Department of Health and Aged Care (2024) Review of General Practice Incentives. Accessed 1 October 2024.
[31] Australian Government Department of Health and Aged Care (2024) Review of MBS allied health chronic disease management services. Accessed 15 September 2024.
[32] Australian Government Department of Health and Aged Care (2024) Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Accessed 20 September 2024.
[33] Australian Government Department of Finance (n.d.) Health Practitioner Regulatory Settings Review. Accessed 1 August 2024.
[34] Snowball K. (2014) Independent Review of the National Registration and Accreditation Scheme for Health Professionals Final Report.
[35] Woods M (2017) Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions - draft report. Accessed 20 September 2024.
[36] Australian Digital Health Agency (2023) National Digital Health Strategy 2023-2028. Accessed 18 July 2024.
[37] Australian Digital Health Agency (2024) National Digital Health Strategy 2023-2028 Delivery Roadmap. Accessed 18 July 2024.
[38] Australian Digital Health Agency (2023) The Digital Health Blueprint and Action Plan 2023–2033. Accessed 18 July 2024.
[39] Australian Government Department of Health and Aged Care (2023) Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report. Accessed 18 July 2024.

Figure 4 Review recommendations



Theme A - Workforce design, development, education and planning

Five recommendations aim to support the development of a sustainable primary care workforce. Collectively, these reforms would contribute to achieving the *Strengthening Medicare* vision by facilitating a more **accessible**, supported workforce that provides care in effective **multidisciplinary teams** working to their full scope of practice and equipped to provide optimal care that meets community needs. These reforms signal a **change in culture** to value primary care as a critical component of the broader health system.

- **Develop a National Skills and Capability Framework and Matrix** (Recommendation 1) to contribute to greater recognition of the skills and capabilities of the entire workforce. The matrix would highlight where scopes of practice align and differ and contribute to workforce planning.
- **Establish a national primary care workforce development program** (Recommendation 2) to support the development and maintenance of the primary care workforce, including students, supervisors, mentors and health professionals. The program would enable a better co-ordinated workforce that recognises and utilises the skills and capabilities for which health professionals are educated, trained and competent.
- **Amend the National Law** to provide a consistent authority of the HMM to give policy directions on both accreditation and registration functions (Recommendation 3). This reform would enable the HMM to signal areas of high priority in support of the development of the primary care workforce.
- **Develop principles and professional capabilities** for primary care practice, collaborative practice and First Nations health care (Recommendation 4). This reform makes explicit in accreditation standards the expectation that education providers prioritise education and training in these critical areas of practice. It also makes explicit the expectation that these principles will be reflected in CPD content and relevant standards and guidelines applicable to CPD, enabling a strengthened focus on learning together as part of a cohesive primary care team.
- **Remove unnecessary barriers to supervision** in primary care education and training, including those that impede cross-professional supervision (Recommendation 5). This reform would address persistent barriers to supervision in multidisciplinary team settings, including a review of MBS rules, guidelines and accreditation standards that act as barriers to workplace-based placement supervision and cross-professional supervision, respectively.

Theme B - Legislation and regulation

Four recommendations seek to enable primary care health professionals to work to their full scope, including across jurisdictions and for evidence-based innovation to be supported. Collectively, the associated reforms would contribute to achieving the *Strengthening Medicare* vision by improving **consumer access** to primary care provided by a range of health professionals and enabling the **multidisciplinary team** to work together more effectively. The reforms would also contribute to a more **contemporary model** of primary care and a **change in culture** to recognise and value the contribution of all health professionals.

- **Implement activity-based regulation of scope of practice** to complement the current focus on title protection of the NRAS, in relation to specific clinical activities (Recommendation 6). This reform would enable a greater number of primary care providers to contribute to care.
- **Review and harmonise existing legislation and regulation** which contain unnecessarily restrictive application of shorthand references to protected titles, and where there is significant inconsistency between jurisdictions in how the legislation and regulation is written or applied (Recommendation 7). This reform would remove unintended barriers to full scope of practice for a range of professions.
- **Enable self-regulated professions to operate at full scope of practice** through targeted legislative amendments to remove existing barriers (Recommendation 8). These would address key issues in legislation and regulation which most impact scope of practice for self-regulated professions, namely the pervasive use of shorthand references to the National Law in legislation and regulation which indirectly regulate scope of practice; and would ensure that the public interest in securing access to essential care is prioritised.
- **Establish an independent mechanism** to provide evidence-based advice and recommendations in relation to workforce design, emerging health workforce roles and models, and major changes to scope (Recommendation 9). This would enable a proactive, evidence-driven and independent approach to the development of the primary care workforce.

Theme C - Funding and payment policy

To support an efficient primary care system which provides better access to the right care, three recommendations are proposed. Collectively, these would contribute to achieving the *Strengthening Medicare* vision by strengthening the **multidisciplinary team,** enabling a range of health professionals to work to their full scope and ensuring the primary care system remains consistent with recognised best practice. These recommendations signal a **culture change** that embraces all primary care health professionals.

- **Introduce a new blended payment model for primary care** (Recommendation 10). This would support the flexibility of care delivered by multidisciplinary care teams, thereby improving access to multidisciplinary care delivered by health care providers working to their full scope of practice.
- **Introduce a bundled payment model for maternity care** (Recommendation 11). This reform would support integrated, holistic maternity care, including midwifery continuity of care models and GP shared care models.
- **Implement new direct referral pathways for specified MBS services which meet defined criteria** (Recommendation 12). This reform would benefit consumers by removing the need to visit a GP to obtain a referral, enabling more timely care and ensuring access to non-GP medical specialists remain affordable.

Summary of findings

The sum of evidence gathered over the course of this Review clearly highlights key opportunities for change to create a primary care system which more effectively responds to community needs.

Figure 5 summarises the approach taken to synthesising evidence across the Review, beginning with the six focus areas informing the Review, and the methods by which these were distilled into the three priority themes and a range of underlying enablers. The figure summarises at a high level the range of benefits and beneficiaries intended through the combined reforms.

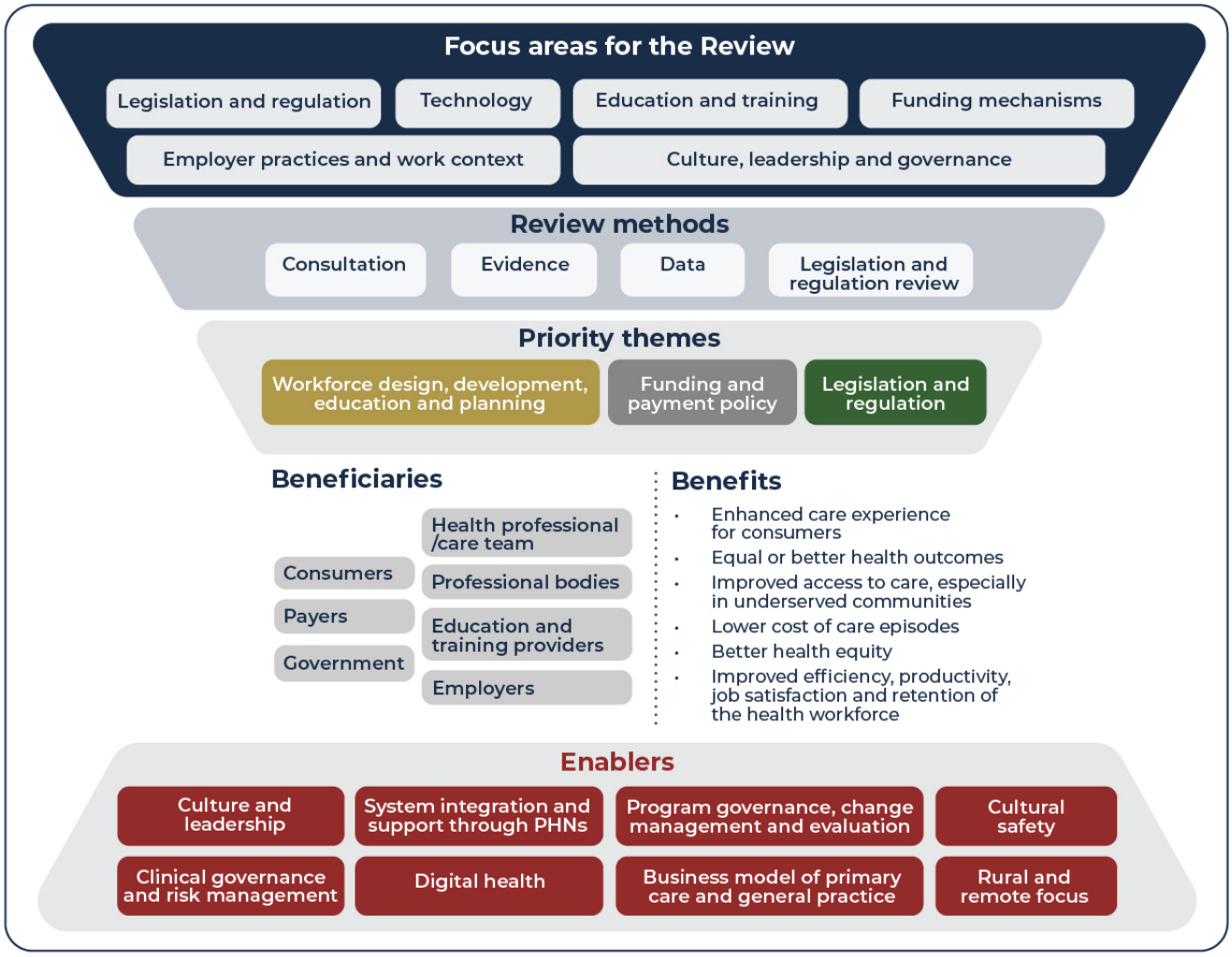
Outlined above, as supported by evidence from broader literature and extensive stakeholder consultation, there is clear evidence of a substantial ongoing issue that sees large parts of the primary care workforce prevented from providing full scope care in a coordinated and collaborative way, consistent with their proven competence. Addressing this issue requires a multifaceted approach to reform.

Furthermore, the Review has highlighted a genuine desire within the primary care workforce to embrace change in the interests of making consumer care the best it can be. Consultation described a vision for primary care that values and respects the contribution of all primary care health professionals, and reaches across other parts of the health care system in the interests of providing the best consumer care. Rather than a limited approach to delivering care based on professional title alone, this vision for the future saw professional skills and competence being applied in a collaborative and flexible way to meet consumer and community need.

“The reform options proposed in this Review must unequivocally affirm the unique and distinctive contribution of each health profession to the primary care ecosystem. This requires systematic efforts to promote trust, respect and cooperation and to create a learning culture, including through promoting a non-rivalrous understanding of each profession’s contribution to primary health care.”

The Australian Psychological Society

Figure 5 Overview of Review and intended outcomes



Future primary care will look different. It will consist of teams that may work together under the same roof or may be separated by distance and connected virtually. It will enable connection between teams and between care providers and consumers, regardless of where they are located. It will be characterised by a willingness to work together, joined by a focus on the consumer and what is in their best interests.

The road to reforming the primary care system to reflect this vision will be lengthy. It is acknowledged that a range of intersecting issues outside the direct scope of this Review also have a significant impact on how primary care is delivered and accessed, including workforce availability and affordability of care. While the reform proposals outlined in this report cannot necessarily resolve all issues facing the primary care system, they have been developed in response to the material barriers emphasised through multiple rounds of consultation and in considering the local and international evidence base.

Consistent with the vision for *Strengthening Medicare*, the Review has identified a range of reforms that would collectively achieve progress in the direction of a consumer-focused, contemporary and strengthened primary care in which consumers are able to more easily access primary care services, multidisciplinary teams are enabled to work and learn together more effectively, primary care is provided according to a more contemporary model and the culture of the primary care sector is improved and drives ongoing innovation and excellence.

Figure 6 provides a summary of the alignment between the reform proposals and the *Strengthening Medicare* vision. The combined reform options are designed to progress the four *Strengthening Medicare* pillars: increasing access to primary care,

encouraging multidisciplinary team-based care, modernising primary care and supporting change management and culture change. In driving change across these areas from a scope of practice perspective, this Review seeks to make an important contribution to broader ongoing reform efforts in the primary care and broader health systems.

The combined intent across the suite of proposed reforms is to progress toward strengthening the primary care system by allowing more health professionals to do more of what they are educated, competent and authorised to do in more circumstances. The reforms are ultimately intended to resolve unnecessary roadblocks, in order to help people across Australia to access the primary care services they need.

Figure 6 How the reform proposals deliver against the *Strengthening Medicare* vision

	Increasing access to primary care	Encouraging multi disciplinary team-based care	Modernising primary care	Supporting change management & culture change
Rec 1 Develop a National Skills and Capability Framework and Matrix	✖	✖	✖	✖
Rec 2 Establish a primary care workforce development program		✖		✖
Rec 3 Amend the National Law to provide a consistent authority of the HMM to give policy directions on registration and accreditation functions		✖	✖	✖
Rec 4 Develop principles for Interprofessional Education (IPE) and interprofessional capabilities for primary care, collaborative practice and First Nations health care		✖		✖
Rec 5 Remove unnecessary barriers to supervision in primary care education and training		✖		✖
Rec 6 Progress activity-based regulation of scope of practice to complement the status quo protection of title approach	✖	✖	✖	✖
Rec 7 Program of review and potential harmonisation of existing legislation and regulation	✖			
Rec 8 Strengthen and standardise the regulatory model for health professions currently operating outside of the NRAS	✖		✖	✖
Rec 9 Establish an Independent Mechanism to provide evidence-based advice and recommendations in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope		✖	✖	
Rec 10 Introduce a new blended payment to enable access to multidisciplinary health care delivered by health professionals working to their full scope of practice in primary care	✖	✖	✖	
Rec 11 Introduce a bundled payment model for maternity care	✖		✖	
Rec 12 Implement new direct referral pathways for consumer access to specified non-GP specialist MBS items	✖	✖	✖	

Enablers and other key considerations

Rec 13 Program governance and reform structure to oversight reforms

Rec 14 Develop a new capacity building and implementation support program for the 31 Primary Health Networks (PHNs)

Rec 15 Develop and implement communications and training strategies

Rec 16 Commit to a shared definition of cultural safety across primary care

Rec 17 Mandate participation by primary care providers in an approved accreditation program

Rec 18 Prioritise implementation of reforms in rural, remote and underserviced areas

5

Proposals for reform

This section provides a detailed summary of each of the proposals for reform. Each of these proposals for reform are supported by underlying recommendations and enablers.

Theme A: Workforce design, development, education and planning

Two reform proposals are presented below relating to workforce design, development, education and planning:

A1. National Skills and Capability Framework and Matrix

A2. Strengthen the capability of the primary care workforce

A1. National Skills and Capability Framework and Matrix

Summary

Designing and sustaining a skilled and responsive health workforce relies on a clear understanding of the health care needs of the community, the services required to address those needs and the workforce available to deliver care, including the practice scope for all relevant professions. Health workforce development must align with health services planning to ensure services can effectively meet community needs. A cooperative approach between community, care providers, governments, professional groups and educators can establish clear workforce objectives and inform workforce design and development.

Health workforce planning relies on accurate and comprehensive data. A range of metrics can support the design, development and planning of the health workforce, including the number and location of available health professionals and the specific skills they can contribute to care. While elements of workforce data are available for some professions (e.g., regulated health professions), there is currently no systematic national data that describes the Australian allied health workforce, including registered and non-registered professions and the health sectors in which they work.[40, 41] In addition, limited information is available at a national level to describe workforce skill and capability, which severely limits workforce planning, decision-making and funding. For these reasons, understanding of the capabilities of the entire primary care workforce is complex.

Identifying and addressing the service needs of the community is also complex. Inter-relationships between primary care and other health and social sectors are generally non-linear, with consumers frequently moving between sectors to access required services.

Health professionals consequently require skills and capabilities that are relevant to a range of healthcare contexts and a clear understanding of their scope of practice boundaries. Ensuring quality care, while supporting innovations to meet consumer and community need, relies on quality education and training provided according to robust standards and underpinning accountabilities. Education providers and accreditation authorities have a critical role in ensuring the quality of education programs that contribute to the health workforce and the alignment of these programs with service requirements. Maintaining a stable pipeline of health professionals whose skills and capabilities are known and understood is instrumental to workforce planning.

Primary care health professionals work within scopes of practice that are defined by several factors, including their qualifications, education, training and competence; the specific authorisations and/or endorsements under which they practice; the practice context, including local authorisations, policies and expectations; and their accountability to required professional practice standards. Commonly, descriptions of practice scope are provided in documents embedded in profession-specific documents, making them challenging to identify. Understanding and making visible the different scopes of practice within which health professionals work is an important contributor to the planning, development and education of the primary care workforce.

Health professions have refined their skills and capabilities over generations, establishing profession-based expertise to meet community need. Understanding what makes each profession unique is an important component of workforce planning. Identifying and recognising where professional skills and capabilities complement each other, or are shared across multiple professions, contributes to workforce flexibility and agility.

[40] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.
[41] Health Policy Analysis (HPA) (2022) Allied health workforce data gap analysis: Issues Paper. Report to the Australian Government Department of Health. Accessed 4 July 2024.

Proposal: The National Skills and Capability Framework and Matrix

One of the recommendations of the *Strengthening Medicare* Taskforce to contribute to the outcome of modernising primary care is to *"Invest in better health data for research and evaluation of models of care and to support health system planning."* [page 9] [42]

Consistent with this recommendation and applying it directly to scope of practice, this reform proposes the development of a comprehensive National Skills and Capability Framework and Matrix (abbreviated for simplicity to the 'Matrix'). This has two core elements:

- A *Framework* which would describe foundational elements that underpin the Matrix, essentially describing the 'what' of the health workforce: what terms we use to describe health professional practice; what health professions, skills and capabilities need to be defined; and what sources of information form the basis of our understanding of professional skill and capability.
- The *Matrix* would be designed to provide an easily navigated representation of the combined workforce skills and capabilities identified from trusted professional practice descriptions, essentially describing 'how' the health workforce combines to provide care. A consumer-facing version of the Matrix would be developed to support consumer understanding of health professional skills and capabilities.

The Matrix would aim to make the skills and capabilities of the primary care workforce explicit and transparent and remove incorrect or unfounded assumptions about health professional scope of practice, including those borne from the current emphasis on regulating scope through protection of title. Consumers, employers, multidisciplinary teams, educators, planners and governments require clarity about how community health care needs are addressed through a mix of professional and workforce skills and capabilities. The Matrix would contribute to this understanding.

The Matrix would complement other national strategies, including development of the National Skills Passport [43] and the Australian Universities Accord [44] Linking the Matrix with the National Skills Passport would appear logical.

The *Strengthening Medicare Taskforce Report* also aims to encourage multidisciplinary, team-based care through *'systems and funding that support comprehensive continuity of care delivered by well-connected teams working together to address people's health needs.'* The Matrix would support team-based care by recognising the skills and capabilities that currently exist in the primary care workforce and strengthening the trust between professions, improving the overall function of teams.

"A high functioning health care team requires recognition of each team members strengths and weaknesses, flexibility, and a safety net for when things get tricky."

University of Melbourne, Faculty of Medicine, Dentistry and Health Science

"No one person can understand the scope of practice of all other members of a multidisciplinary team as these will differ, and it is the responsibility of each health professional to voice and work to their individual scope of practice, seeking appropriate education to expand their scope of practice when necessary. Similarly, teams have a professional responsibility to learn about other health professionals working within the team. This is good work practice and demonstrates an environment of respect and is instrumental in building trust."

Australian Nursing and Midwifery Federation

The Matrix is unique in its proposed structure and potential use. By mapping the skills and capabilities of the broad range of care providers that contribute to primary care, the Matrix would inform community, the workforce, employers and health services and contribute vital information to workforce planning and development. A visual representation of this data would enhance the usefulness of the Matrix across all users.

[42] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.
[43] Australian Government Department of Education (2024) National Skills Passport Consultation Paper. Accessed 22 July 2024.
[44] Australian Government Department of Education (2024) Australian Universities Accord. Accessed 22 July 2024.

A range of workforce descriptions are available. Most provide the expected general skills or capabilities for health professions (or a range of practice levels within a profession), commonly in a tabular format. Some provide descriptions of practice expectations relating to advanced practice. However, existing examples fail to define the specific skills and capabilities for the entire health workforce at a level that highlights practice scope.

The proposed Matrix would most closely resemble the Canadian Institute for Health Information matrix of nursing professional capabilities described below. However, this matrix provides intraprofessional detail, rather than a representation of multiple health professions, as proposed by the Matrix, and does not allow representation of the broad workforce.

Examples of skill and capability frameworks and matrices

A range of skill and capability frameworks and matrices have been developed, internationally and within Australia, to support health workforce planning and development. Some provide generic skill or capability descriptions that apply across a range of professions and/or performance levels and others highlight specific capability differences across a workforce. Commonly, skills and capabilities are grouped according to practice areas such as professional practice, leadership and research.

The Canadian Institute for Health Information has developed a web-based matrix, searchable by jurisdiction, that describes the legislated scopes of practice for registered nurses, registered psychiatric nurses and licensed practical nurses according to province.[45] The document defines **common capabilities** and underlying skills grouped in four areas (assessment and therapeutic management, treatment/interventions, pharmacotherapy and other), and indicates whether each is within scope, restricted or not within scope.

Example: It is within scope for a registered nurse in Saskatchewan to perform an electrocardiogram and order X-Rays according to restrictions, but it is out of scope to apply a cast.

Skills for Health England have developed an Employability Skills Matrix for the Health Sector[46] which summarises the employability **skills** required for work at different levels of health care, as defined and agreed for use across England. Skills are grouped in three areas: communication, use of mathematics and information technology; teamwork; and personal. Within each level, skills are linked with indicative education and training levels.

Example: At career level 1, employability skills for use of IT include:

- Use basic computer skills
- Follow recommended practices to keep information secure.

[45] CIHI (Canadian Institute for Health Information) (n.d.) Legislated scopes of practice across Canada: Registered nurses. Accessed 22 July 2024.
[46] Skills for Health (n.d.) Employability Skills Matrix for the Health Sector. Accessed 22 July 2024.

NHS England have developed several capability frameworks:

- Multiprofessional Framework for Advanced Clinical Practice in England [47] which describes the **core capabilities** for health and care professionals working at an advanced level of clinical practice, according to an agreed definition of advanced clinical practice and applicable to all advanced clinical roles. Capabilities are grouped in four areas: clinical practice, leadership and management, education and research.

Example: Clinical Practice: "Practise in compliance with their respective code of professional conduct and within their scope of practice, being responsible and accountable for their decisions, actions and omissions at this level of practice."

- Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care in England. [48] This document recognises the advancing roles nurses undertake in primary care and their contribution to multiprofessional teams. Capabilities are grouped under four domains (person-centred collaborative working; assessment investigations and diagnosis; condition management, treatment and prevention; leadership and management, education and research) and acknowledges the requisite knowledge underpinning capabilities.

Example: Capability 1 Communication and consultation skills. The ACP (Primary Care Nurse) must: Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening, e.g. frequent clarifying, paraphrasing and picking up verbal cues such as pace, pauses and voice intonation.

Primary Care and General Practice Nursing Career and Core Capabilities Framework. [49] This document describes the capabilities expected of nurses across a spectrum of career points from support work through to consultant level registered nurse. Capabilities are described in three tiers from foundational through to independent practice and are grouped into four domains. The document provides a career framework which describes the levels of nursing within primary care, and a capabilities framework which describes the capabilities needed for safe and effective care.

Example: Tier 3 (independent practice at the highest level) communication and consultation skills require the staff member to: "Critically appraise communication strategies and be able to optimise communication approaches appropriately using skills such as active listening e.g., frequent clarifying, paraphrasing, and picking up verbal cues such as pace, pauses and voice intonation."

(Note that this capability corresponds with that described in the Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care in England above).

Across Australia, skills and capability frameworks have been developed to support a range of initiatives. The Victorian Government Capability Framework for the Mental Health and Wellbeing Workforce [50] 'Our workforce, our future' describes the knowledge, skills and 'ways of working' by introducing a common language for the multidisciplinary mental health workforce. The framework provides practice principles, 15 capabilities and relevant outcome statements.

Example: Capability 2 (working with Aboriginal consumers, families and communities) requires key knowledge and skills that include an understanding of "current Victorian guidelines, policies and frameworks that guide culturally safe and responsive care for Aboriginal consumers, families, carers, supporters and communities".

South Australia Health Allied Health Advanced Clinical Practice Statewide Framework [51] describes skills and attributes for advanced clinical practice, including core and service specific capabilities arranged in four domains. The framework is intended to inform clinical governance for advanced clinical practice roles.

Example: Core capabilities for allied health advanced clinical practice requires the practitioner to "Provide evidence-based therapeutic interventions drawing upon diverse expert knowledge of contemporary methods, discipline principles, practice and subject specific competence".

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[47] NHS England (2017) Multiprofessional framework for advanced clinical practice in England. Accessed 22 July 2024.
[48] Health Education NHS England and Skills for Health (2020) Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care in England. Accessed 22 July 2024.
[49] Health Education England, NHS England, NHS Improvement, Skills for Health (2021) Primary Care and General Practice Nursing Career Core Capabilities Framework. Accessed 22 July 2024.
[50] Victoria State Government. Department of Health (2023) Introduction to the capability framework. Accessed 22 July 2024.
[51] Government of South Australia Allied and Scientific Health Office (2023) Allied Health Advanced Clinical Practice Statewide Framework: SA Health. Accessed 22 July 2024.

Learning from these examples, the proposed Matrix will provide agreed skills and capabilities and highlight primary care workers for whom there is evidence to indicate their competence in these areas.

The Matrix would serve an instrumental and foundational role to the significant reforms detailed in this report by providing a robust base that clearly articulates the skills and capabilities of the primary care workforce to inform policy decisions relating to education and training, legislation and regulation and funding and payment.

Development of the Matrix

The Framework would be developed to provide a foundation for the Matrix by establishing shared language and definitions and identifying the sources of information used to develop the Matrix. Constructing the Matrix itself would require the collation and presentation of verified skill and capability descriptions in a user-friendly format.

It is envisaged that the first version of the Matrix would focus on skills and capabilities identified at entry to practice (as defined by each discipline). However, it is acknowledged that post professional entry, an individual's scope of practice is dynamic and changes in response to many factors, including further education and training, professional experiences, changes in competence, and the working context. Detailing the skills and capabilities developed through advanced/advancing practice pathways would enable recognition of the impact these skills and capabilities have on practice scope and would inform regulatory processes. A secondary positive impact of detailing the skills and capabilities associated with advanced practice is the provision of clear pathways for individual health professionals to review and work towards.

Acknowledging this, subsequent versions of the Matrix could include the skills and capabilities that reflect advancing and advanced practice, where these are formally recognised, e.g., rural generalist capabilities.

Future versions may recognise skillsets that apply outside of primary care, further contributing to a comprehensive view of the health workforce.

"A widely accessible digital competency library would enable planners, funders or employers to compile a profile of the skills and capabilities needed to serve a specific health need, and to identify the range of professions or occupations best equipped to meet that need. This approach would encourage greater flexibility in the design of health care teams and encourage a mindset whereby no profession has exclusive ownership of the skills and competencies within their usual scope of practice."

Allied Health Assistants' National Association

"It is important that this framework and matrix take into account the progressive nature of health practitioners' skills, experience and competency building during the stages of health professional training and over time – from student to advanced practitioner."

Medical Deans of Australia and New Zealand

"While the proposed focus is on entry-level skills and capability, there is a risk of limiting the intended impact of the framework and matrix, and the understanding of scope of practice for allied health professionals who have an extensive and diverse skillset."

Consultation participant, government perspective

Early development opportunities

An inclusive approach to the development of the Framework and Matrix would be employed. To begin, skills and capabilities that are clearly identifiable in professional practice descriptions for a range of professions would seem a logical starting point. An inclusive approach that recognises the skills and capabilities of a cross-section of the primary care workforce, including the assistant, technician and support workforces alongside regulated and self-regulated professions, was supported by stakeholders. As a starting point, early versions of the Matrix could therefore describe where the following professional capabilities are identified in the primary care workforce:

- Collaborative practice
- Cultural safety
- Vaccination.

Consultation perspectives about the proposed Matrix

The Matrix coalesced as a new concept from extensive consultation conducted during the Review process. A cross-section of views, provided in response to the proposal, has informed the current vision of the Matrix. This section summarises common perspectives.

Anticipated benefits

Formal recognition of the breadth of skills and capabilities of the entire primary care workforce across the continuum of care was welcomed and viewed as having the potential to ease the interprofessional fear that arises from a poor understanding of colleagues' skills and paving the way for a more trusting and cohesive care team. Development of a shared language for workforce skills, capabilities and scope descriptions was described as an essential and welcome achievement.

Considerations and suggestions

In addition to the general support for the Matrix identified across all formats of consultation, a range of considerations were raised and are summarised below.

- **Matrix format.** Providing the Matrix as a living, dynamic and agile tool, readily updated to reflect contemporary professional practice was viewed as fundamentally important.
- **Data sources.** Without exception, stakeholders expressed the view that the Matrix should be based on trusted and verifiable sources of information and for its intended use to be clearly defined. Basing capabilities recognised in the Matrix on common standards and competencies was important to many contributors.
- **Barriers to development.** Entrenched cultural mistrust was raised as a potential barrier to the Matrix development, with predicted challenges identified in establishing common language and definitions, despite the predominant view that this was a significant and valued aim.

"The process is likely to create conflict between professions who don't agree with each other's scope of practice, skills and capabilities as they feel there is encroachment on professional boundaries."

Consultation participant, government perspective

- **Recognising professional expertise.** While the view that the Matrix should represent skillsets, not professions, was expressed, the counterview was also identified which maintained it was important to specifically identify what contributed to individual professional expertise, referred to as 'what makes professions unique'. Similarly, illuminating capabilities developed through specialisation was viewed as significant, as was acknowledging that although multiple professions may be competent to undertake a specific task, professional expertise will drive the decisions made, and actions taken, in response to patient outcomes.

"For the National skills and capability framework and matrix to genuinely support better recognition of primary care health professionals' skills and capabilities, it is important that it articulates profession-specific skills and capabilities and also contextualises each profession's contribution through multidisciplinary care teams in the provision of patient-centred health care."

Pharmaceutical Society of Australia

- **Recognise the practice context.** Specific contexts may impact capabilities, and this should be recognised in the Matrix. For example, rural and remote practice of First Nations care, which may require a unique application of recognised capabilities.
- **Reflect, not define scope.** Many acknowledged that the Matrix would not define scope, rather it would serve to collate, visualise and support better utility of existing descriptions of skills and capabilities that are found in a range of profession-specific artefacts. Reflecting established descriptions of skill and capability available from a variety of trusted sources and highlighting common capabilities was noted to support workforce design, development and planning. Use of the Matrix to enable task exchange or substitution was not supported.
- **Link with enabling mechanisms.** Linking identified skills and capabilities with a range of enabling factors was considered an important use of the Matrix for the betterment of the primary care workforce. For example, where professions can demonstrate, through recognised, trusted profession-based practice descriptions, their ability to perform a role, authorisation, remuneration, payment, legislation and regulation should reflect recognised capability.
- **Support for multidisciplinary care.** The Matrix would not support an atomised view of professions for the purpose of removing roles from established providers. Rather, it would support all professions to contribute to the primary care workforce consistent with established competence.
- **Support innovation.** There was a common view that the Matrix should contribute to, rather than stifle, innovation.

"It is essential that the framework and Matrix does not limit innovation, become a vehicle of further professional protectionism or restrict the adoption of new practices and technologies."

Consultation participant, government perspective

Other suggestions included:

- Capturing both technical skills and capabilities alongside the professional paradigm within which the skills are placed; for example, the difference between Western physiology and the basis of Chinese medicine.
- Identifying capabilities that contribute to functional multidisciplinary teams in addition to technical skills. These would include, for example, person-centredness, communication, conflict resolution and an understanding of the team-based approach to care.

Intended outcomes

The Matrix would enable broad visibility of the entire primary care workforce and highlight where scopes of practice align, overlap and differ, through comprehensive mapping of the skills and capabilities of all health professions and the paraprofessional (assistant, support and technician) workforce. In developing the Framework, early work would focus on establishing common national language and definitions that would be foundational to the Matrix and do not currently exist.

Use of the Matrix

The Matrix would complement existing workforce initiatives and strategies including those undertaken by the Department of Health and Aged Care and national workforce strategies, including those for the medical, nursing and allied health workforces. To effectively contribute to workforce planning, the Matrix would establish links with other agencies that gather and collate health workforce data, including Jobs and Skills Australia, Rural Workforce Agencies and State and Territory governments.

Use of the Matrix, particularly in conjunction with comprehensive workforce data and modelling, would inform policy decisions, including those focused on education, legislation and regulation. The education and training needs of the future health workforce would be informed by the Matrix. Accrediting authorities and educators across all levels of education could use the Matrix to inform the design and development of education and training programs in response to practice development, innovations and community need.

The Matrix could also support an activity-based approach to legislation and regulation (see *Section B1*) by identifying the range of health professionals equipped with the skills and capabilities to provide activities in response to community needs.

Possible uses of the Matrix can be identified at the national and local levels.

At a *national level*, the Matrix would inform workforce design, development and planning by:

- Identifying the existing workforce skills and capabilities, including highlighting skillsets common to multiple professions
- Articulating education, training and capability development opportunities for individuals
- Recognising advanced skills
- Enabling the identification of workforce gaps
- Informing decisions regarding the most efficient and appropriate use of the skills and capabilities that currently exist in the workforce, including where emerging roles are identified
- Contributing to innovation and exploration of new models of care.

At *local, regional and sectoral levels*, the Matrix would inform the most effective approach to meet community need through several mechanisms, including:

- An improved understanding of the capabilities of the entire workforce, including supporting and assisting team members
- Recognition of opportunities to investigate and establish new models of care based on community need
- More streamlined authorisation processes across jurisdictions, which could reduce or remove the need for repeat assessment/credentialling processes
- Recognition of gaps in service need that require resolution
- Health professionals could use the Matrix to identify the skills and capabilities associated with advancing career pathways to inform their learning
- Employers could use the Matrix to inform the design of their workforce, based on clear expectations of professional capabilities and improved knowledge of the available team members, including those with recognised generalist capabilities such as rural generalists.

Consultation indicated that providing the Matrix in several formats would ensure its most effective use. A consumer-facing version of the Matrix, translated into easily understood language, would assist consumers to better understand the role of health professionals. An interactive digital format would provide a useful guide for employers, funders, service providers and health professionals to build the most effective team to meet community needs. This version could also be useful for education providers, health professionals and accreditors in the design, development and assessment of curricula, particularly where service planning gaps are identified and require forward planning.

Health professionals could use the Matrix to inform team-based care that recognises the skills and capabilities of all health professionals, functions under the principles of trust and respect, informed by the Matrix, and effectively applies recognised skills and capabilities to address consumer and community needs. Development of a companion self-assessment tool would support health professionals to identify skills and capabilities that require further development to support their practice.

Impact on multidisciplinary teams

The Matrix would contribute to workforce design, development and planning by illuminating workforce potential through recognition of the specific skills and capabilities of all contributors to primary care. This would enable the building of primary care teams based on the specific needs of the consumer and community, and the availability, preference and experience of health professionals and teams.

Improved team trust and cohesiveness is a potential outcome of a well-designed Matrix, based on trusted sources of information and clear descriptions of skill and capability.

Teams could benefit from members who are recognised for their skill and capability and feel professionally fulfilled. Individual health professionals could use the expanded (future) version to identify a career pathway that includes advancing skills and capabilities.

The process of developing the Matrix would provide an opportunity for the broader team to be informed of the skills and capabilities of colleagues, to build consensus language and establish a shared purpose for the Matrix.

Enablers

Design and development of the Matrix will be served by **early and consistent inclusive consultation** involving consumers, First Nations representatives, rural and remote practice representatives, all members of the primary care community, PHNS, educators, accreditation authorities, professional organisations, regulators, employers and insurers. Specific inclusion of regulated, self-regulated and professions regulated outside of NRAS or self-regulation at all relevant steps in the development of the Matrix will be critical to its success.

Comprehensive communication and engagement with stakeholder groups during development and implementation, noting that early versions of the Matrix will focus on the skills and capabilities of health professionals at entry to practice. The dynamic and changing nature of scope of practice post qualification will be acknowledged, recognising the full capacity of the workforce and preventing any unintended restrictions or negative consequences.

Digital infrastructure will be critical to successful implementation, and effective use, of the Matrix across all stakeholders. Ensuring optimal digital functionality, through specific usability testing, will be essential.

Effective change management processes, designed to inclusively engage with all stakeholders and provide a smooth transition from development to implementation, will support effective reform.

The Matrix provides a foundational reform that will both contribute to, and benefit from, other reforms described in this Review. Improved recognition of the skills and capabilities of all members of the health care team would enable the building of multiprofessional teams founded on individual and combined capabilities. Building better teams enables the best use of the entire workforce. Establishing teams comprised of a range of health professionals could contribute to more effective team-based learning, with resultant consumer benefits. However, enabling all health professionals to contribute to the primary care team requires reforms in other areas, including legislative, regulatory and payment policy reforms that enable health professionals to perform, contribute and participate in the primary care system through the roles for which they are competent.

The Matrix could shape **education, regulation, legislation, and payment settings** that enable all team members to contribute their full scope of practice to care. Linking the Matrix with new **policy initiatives**, including program design and evaluation, would also support optimal use.

Recommendation 1

Health Ministers agree to the development of a National Skills and Capability Framework and Matrix (the Matrix) to support workforce design, development, education, and planning in primary care.

1.1 Establish an independent, national mechanism, reporting through to Health Ministers to create, maintain, develop and promote the Matrix. This may be incorporated as part of Recommendation 9.

1.2 Implement an ongoing program of education, promotion and adoption of the Matrix to support awareness of and adoption by consumers, the health workforce, employers and higher education providers, accreditors and funders.

1.3 National Boards and accreditation authorities regularly review the Matrix to align accreditation and registration functions relating to standards, codes, competencies and guidelines for nationally regulated health professions.

1.4 Professional bodies, in their capacity as self-regulating entities, regularly review the Matrix to align accreditation and professional standards, functions relating to standards, codes, competencies and guidelines for self-regulated health professions.

Implementation

Establishing an entity responsible for the development and implementation of the Matrix will be essential. *Section B2* recommends the establishment of an independent mechanism to undertake this role as a priority.

The development of the Framework will provide the foundation for the Matrix. It will be important to establish clarity on the sources of information that will be referenced, principles, definitions, intended use, governance, processes and accountability for reviewing and updating the Matrix. Key implementation steps within the short (less than two years), medium (between two and five years) and long-term (more than five years) include:

- **Establish inclusive program leadership, oversight and governance processes** to support the development and implementation of the Matrix. Inclusive consultation with all contributors to primary care would be required early and in an ongoing capacity during the work. **(Short-term)**
- **Establish a clear vision** for the Matrix, including its intended purpose, desired outcomes, and position in the context of wider reforms. Achieving this would require significant consultation and consensus building. **(Short-term)**
- **Establish program design processes that underpin the Framework and Matrix** development and implementation, including those pertaining to:
    - Stakeholder engagement
    - Communication and dispute resolution
    - Establishment of mechanisms to support stakeholder engagement in the Matrix development
    - Identification, validation and obtaining of trusted sources of material
    - Digital technology to support the Matrix, including extensive usability testing
    - Change management to support implementation, including comprehensive stakeholder education
    - Leadership mechanisms to support implementation
    - Quality assurance, including the consistent, regular review of, and obtaining regular feedback about, the Matrix use
    - Establishment of links with workforce planning organisations and processes. **(Short-term)**

- **Engage with stakeholders.** Regular and ongoing engagement with a broad range of stakeholders, including consumers, First Nations peoples, rural and remote health professionals, all primary care professions, PHNs, the paraprofessional workforce, educators, accreditation authorities, professional organisations, regulators, employers and insurers. Identify and manage concerns early within engagement processes. **(Short-term)**
- **Develop the Framework.** Cross-professional consensus will be required to establish and communicate the foundations for the Matrix in the Framework, including:
    - Definitions and terminology for use in the Matrix
    - Sources of information to be referenced in the Matrix
    - Intended use of the Matrix and guidelines to support its use. **(Medium-term)**
- **Develop the Matrix.** Development will require the following steps:
    - Scope and secure relevant information from established sources.
    - Collate findings to develop the Matrix.
    - Conduct usability testing and refine the Matrix, according to established processes. Consider trialling implementation in multiple sectors of the community to assess functionality.
    - Develop education packages and training resources to support use. Provide multiple formats for stakeholders to engage with the Matrix.
    - Enact agreed change management and leadership processes. **(Medium-term)**
- **Implement quality assurance measures** including regular, systematic reviews and updates, undertaken according to defined procedures, to ensure the Matrix remains current and reflective of contemporary practice. Gather regular feedback from those who use the Matrix to ensure it continues to achieve its objectives. Ensure systematic monitoring of the use of the Matrix against established criteria to inform future developments. Evaluation of the impact on education, training and workforce planning according to established processes. **(Long-term)**

Successful implementation of the Matrix would hinge on its accuracy, currency, the commitment of all parties to implement and use the Matrix in the manner intended, effective digital technology and close attention to the Matrix design, usability and maintenance.

Links to other reforms would contribute to the effectiveness of the Matrix, including specific reforms in legislation, regulation, funding and payment policies that support contributions of all members of the primary care workforce.

A2. Strengthen the capability of the primary care workforce

Summary

Effective primary care requires a highly-skilled, consumer-focused, collaborative and sustainable workforce. The primary care workforce functions within the broader health and social care service sector, requiring primary care providers to understand and recognise the implications of this wide health landscape for consumer care. The development of primary care capability relies on functional relationships between community, the local (and broader) health system, education providers and professional organisations.

Developing and maintaining a skilled and stable primary care workforce is enabled by quality consumer-focused education and training, appropriately resourced workforce support, and an inclusive, collaborative approach to workforce development. Context specific learning experiences that facilitate a deep understanding of primary care and its relationship with the broader health system are essential, in parallel with the development of specific skills and capabilities needed to provide care in this setting and a fundamental understanding of own and others' scope of practice. Consultation highlighted examples of effective education and training provided in primary care and a range of support measures available in this context. However, cross-professional inconsistencies exist in the provision of, or access to, relevant development programs and supports.

An objective of the National Law is to 'enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.' [52] Consistent with this objective, the Review sought to identify issues that challenge the development, function and maintenance of the primary care workforce, and to determine mechanisms that could be employed to address these challenges and enable primary care health professionals to work to their full scope of practice.

A range of issues impact workforce development, many of which are not unique to Australia. The World Health Organization highlights that *"countries at all levels of socioeconomic development face, to varying degrees, difficulties in the education, deployment, retention, and performance of their workforce"* [page 10], and acknowledges the importance of the health workforce in achieving health objectives into the future. [53] Consultation identified that, in the context of Australian education and training, challenges can be observed at both the pre- and post-professional entry level. Rural and remote areas commonly experience workforce development challenges particularly acutely and require context relevant and carefully considered solutions.

Pre-professional entry education, training and development

The inclusion of high-quality primary care education and training experiences in professional entry education programs is an important mechanism to establish a pipeline of skilled primary care health professionals. Education providers and accreditation authorities have an essential role in defining the expectations for primary care practice and in ensuring graduates are equipped to deliver safe and effective clinical care.

Practice expectations are referred to using a range of terms, including competency standards, standards for practice, practice thresholds, performance outcomes and graduate outcomes. Professional capabilities identify the knowledge, skills and professional attributes needed to safely and competently practice the relevant health profession in Australia. [54] This Review acknowledges that Ahpra is currently engaged in consultation regarding the guidance they provide for registered professions to develop professional capabilities. [55]

Supervised practical training opportunities provided in the workplace, also referred to by a range of terms including clinical placements, placements, experiential learning, professional experience placement (PEP), professional placement, professional experience, work placement, midwifery practice experience (MPE), clinical experience, clinical attachments, practice placements, clinical internship, clinical rotation, clinical observation, workplace-based learning and work-integrated learning (subsequently referred to as 'placements'), are an important contributor to ensuring work-ready health graduates who meet defined practice expectations.

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[52] Australian Government. Health Practitioner Regulation National Law Act 2009 (Cth), sch 1 'Health Practitioner Regulation National Law', pt 1 'Preliminary', s 3 'Objectives', 2(f).
[53] World Health Organization (2020) Global strategy on human resources for health: Workforce 2030. Accessed 15 September 2024.
[54] Ahpra & National Boards (2023) Glossary of accreditation terms. Accessed 24 July 2024.
[55] Ahpra & National Boards (2024) Have your say: Guidance on developing professional capabilities. Accessed 15 September 2024.

Quality training experiences include those in which students are exposed to a range of relevant and practical experiences, across a variety of primary care settings, supervised by an appropriately qualified, skilled and engaged supervisor. Furthermore, quality learning experiences should reinforce the knowledge, skills and behaviours that support culturally safe practice and develop an understanding of important care principles for First Nations peoples, including recognition of the importance of community to consumer health and of trusted relationship building in the provision of care. Learning experiences should be free from racism for all participants and highlight the impact of racism on First Nations community and care providers. Strong partnerships with the Aboriginal and Torres Strait Islander community-controlled sector are important to achieve this aim.

While some professions include a significant focus on primary care in pre-professional entry programs, others predominantly rely on the acute care sector for placements. There are a range of reasons for this, including greater availability of qualified supervisors to contribute to training, and the institutional ability to provide training at scale. However, early exposure to acute care training opportunities has created a view, for some professions, that the hospital system represents the pinnacle of career experience, and that primary care is somewhat inferior. Addressing this persistent social and cultural view is important for the long-term sustainability of the primary care workforce and will require efforts across a range of stakeholder groups.

"Achieving effective integration of primary care into curricula is not only an education responsibility but requires societal, strategic and political shifts towards prioritising primary care."

Council of Deans of Nursing and Midwifery

Providing education and training in primary care enables students to develop the profession-specific skills and capabilities required for this care setting, along with the business skills required to support primary care practice. For example, an understanding of Medicare billing practices and engagement with the National Disability Insurance Scheme (NDIS).

Several factors affect the provision of quality training opportunities that prepare health professionals for primary care practice. These include structural factors such as the establishment of necessary partnerships to support training, legislative factors that can impact training and the cultural factors alluded to earlier that, for some professions, place a lower value on primary care when compared to other health settings. Consultation highlighted that barriers inconsistently affect professions. However, where present, barriers work to actively limit training in primary care, with a detrimental effect on the development of the primary care workforce.

Established Australian Government supported programs enable education and training of the primary care workforce, particularly the medical workforce. Exploration of the possible expansion of these programs to a greater number of health professions would appear prudent to support the development of the entire primary care workforce. Opportunities to achieve this are highlighted in the following sections.

The predominant factors that challenge the provision of quality education and training in primary care include:

- Limited partnerships between education providers and primary care providers
- Limited and inconsistent support for students to complete training
- Limited and inconsistent support for quality student supervision.

Limited partnerships between education providers and primary care providers

Many health professional programs include supervised, work-based placement training. This training provides an opportunity to experience the practice environment, to convert theoretical knowledge into practical skill and to develop a clear understanding of practice scope (including own and that of other members of the multidisciplinary team).

The inclusion of supervised placement experiences in the primary care setting is not routinely available for all health professions. Partnerships between universities and primary care health professionals, including those operating in private practices, are necessary to support training, yet challenging to establish.

Financial disincentives actively prevent the provision of placement supervision within pre-professional entry programs, including:

- Lost income. Student observation, coaching and instruction often results in a reduced consultation capacity, and a consequent loss of income that is inconsistently compensated for across professions.
- Supervising health professionals is necessary to support training of students. For some primary care professions, providing student learning opportunities may result in financial cost to the supervisor due to uncertainty regarding eligibility for MBS rebates where a student is involved in the consultation. Generally, MBS items require services to be delivered by eligible practitioners (with a Medicare provider number) to eligible patients and students do not meet the definition of an 'eligible practitioner'. A strict interpretation of this rule limits practical opportunities for students to learn and develop their skills and capabilities under supervision. To support patient safety and optimal educational outcomes, while maintaining practice viability, a review of MBS billing rules that apply where students are involved in the consultation is required.
- Physical infrastructure required to support training. Health professionals may require the establishment of additional, or modified, consulting and debrief spaces to support the provision of effective training opportunities. Establishing effective training facilities is not supported for many professions.

Limited and inconsistent support for students to complete training

Where unavailable locally, students may be required to relocate to access training opportunities. This brings a range of challenges, including the need to source and fund temporary accommodation, the inability to fulfill local work commitments and the need to cater for families. Adequate and readily available student support is essential to enable students to complete training requirements.

Opportunities

Programs that provide student support for training are available inconsistently across professions. The recent expansion of the Commonwealth Prac Payment Scheme [56], although welcomed by many, is limited to teaching, nursing, midwifery and social work students. Extending this program to other disciplines would greatly strengthen the level of training support across the primary care sector.

Limited and inconsistent support for quality student supervision

Effective supervision is a significant component of quality education and training. Supervision of placement experiences is important to ensure public safety while providing critical learning experiences that support student development. Supervisors have a significant role in shaping the development of student knowledge and skills and in preparing students for the workplace.

Inconsistencies can be identified in the terminology used when referring to supervisors and the supervisory role. For example, a range of terms are used to indicate a supervisory role, including preceptor, supervisor and clinical supervisor.

There are also inconsistencies in the support available for supervisors, and the expectations of the supervisory role. For many professions, this valuable role is not specifically or adequately resourced. Consequently, supervisors frequently supervise students without remuneration and do so in addition to their regular workload, including direct clinical care and business activities.

Conversely, some professions provide specific training and support for workplace supervision, along with expected goals for the role. For example, the Remote Vocational Training Scheme, which links vocational trainees with qualified and experienced supervisors to support their training. [57] Ahpra has developed a supervised practice framework, guidelines and a fact sheet for supervised practice. However, the framework does not apply to student training, nor does it apply to all health professions. [58]

Inconsistent expectations for supervision can impact the quality of supervision and ultimately the student experience, including their view of primary care as a valid and attractive working environment.

Cross-professional supervision can enhance the student learning experience. Supervision provided by another profession can provide an opportunity for students to engage with a different perspective and develop an understanding of the role and scope of other professions. There are also efficiencies in this type of supervision, particularly in the context of skills shared across professions. For example, students from a range of professions could learn to undertake a blood pressure reading from a single supervisor.

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[56] Australian Government Department of Education (2024) Commonwealth Prac Payment. Accessed 12 July 2024.
[57] RVTS (Remote Vocational Training Scheme) (n.d.) Fellowship training for doctors in rural, remote and First Nations communities. Accessed 1 August 2024.
[58] Ahpra & National Boards (2022) Supervised practice framework. Accessed 15 September 2024.

Cross-professional supervision can complement that provided within the profession. This alternate model of supervision has been used in rural and remote areas. In this case, discipline-specific supervision provided remotely links with the practice environment where students are supervised by members of another profession. This model of supervision may enable students to experience practice-based learning even where local profession-specific supervision is unavailable. While cross-professional supervision should not replace profession-specific supervision where this is considered most appropriate, it may enable positive student learning opportunities. However, for some professions, barriers exist to cross-professional supervision. It is essential to address all existing barriers to supervision, including those that impede cross-professional supervision, and for relevant changes to be reflected in accreditation standards and training guidelines.

Supervisors can also play an important role in completing workplace-based assessments. Most professions specify that the significant role of assessment should be undertaken by a profession-specific supervisor. This Review does not intend to challenge this expectation.

Opportunities

The Practice Incentives Program (PIP) teaching payment is an established initiative that supports quality supervision in primary care settings.[59] This program provides general practices with financial support to provide teaching sessions for undergraduate and graduate medical students. The payment compensates practices for the reduced number of consultations that can be performed when providing quality student teaching. It is acknowledged that this payment mechanism forms part of a broader review of GP incentives which is currently underway. The consultation briefing for this Review, released in July 2024, indicates that payments to support teaching will be retained within broader proposed changes.[60]

Given that all primary care health professionals who provide student training will experience similar financial disadvantage associated with the necessary time required to provide training, and a resultant reduced client care load, expansion of this existing program to other professions would appear logical to support the development of the primary care workforce.

To support quality placement experiences, the National Placement Evaluation Centre[61] seeks to evaluate and enhance the quality of placement experiences. The centre provides a range of tools designed to capture data that describe placement experiences from the perspective of the student and the supervisor. Initially developed to evaluate nursing and midwifery placements, the centre has plans to expand to other professions.

Ahpra has developed a draft summary of good practice approaches to clinical placements.[62] This document, currently in progress, highlights important contributors to effective supervision based on a review of the literature.

Establishing delegation and supervision frameworks that support Allied Health Assistant training and practice is similarly essential. The Review acknowledges work that has been undertaken, and is underway, in this context, including the development of several frameworks that support the important work of allied health assistants across jurisdictions.[63, 64, 65, 66]

It is essential that support for education and training in primary care is available to all professions. To achieve this outcome, it is necessary to address existing barriers that impact training, including those that impede the availability of quality workplace-based supervision and training and the inconsistent availability of support for students to participate in practical training. Efforts to remove barriers to, and provide support for, primary care specific education and training were consistently supported during consultation. However, mandating a specified duration of learning in this sector was not favoured, nor considered feasible given the present barriers.

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[59] Australian Government Services Australia (2024) Practice Incentives Program Teaching Payment. Accessed 1 August 2024.
[60] Australian Government Department of Health and Aged Care (2024) Review of General Practice Incentives. Accessed 1 October 2024.
[61] National Placement Evaluation Centre (2024) The Australian National Placement Evaluation Centre. Accessed 15 September 2024.
[62] Ahpra & National Boards (2024) Public consultation now open - draft guidance on embedding good practice in clinical placements, simulation-based learning and virtual care in student health practitioner education. Accessed 15 September 2024.
[63] SARRAH (Services for Australian Rural and Remote Allied Health) Building the rural and remote allied health assistant workforce. Accessed 1 August 2024.
[64] Office of the Chief Allied Health Officer Clinical Excellence Queensland (2022) Allied Health Assistant Framework. Accessed 9 July 2024.
[65] Victoria Department of Health (2024) Supervision and delegation framework for allied health assistants. Accessed 15 September 2024.
[66] NSW Government (2020) Allied Health Assistant Framework. Accessed 15 September 2024.

Primary care training and development opportunities post-professional entry

Supporting health professionals to maintain and enhance their skills contributes to the delivery of high-quality care and workforce sustainability.[67, 68]

Consultation highlighted four important areas in which health professional education and training and development could be improved:

- Availability of relevant primary care education and training opportunities
- Access to relevant education and training
- Access to support provided by a mentor, peer support and/or coaching
- Access to relevant multiprofessional learning opportunities.

Availability of relevant primary care education and training opportunities

The development and availability of relevant primary care education and training opportunities is important to support, develop and enhance health professional knowledge and skills. Education and training in this context may be provided, for example, through formal post-entry qualification education programs, informal workplace-based education and training sessions or CPD opportunities. A range of relevant education and training offerings is critical for workforce effectiveness, agility and sustainability. There is a need for more primary care-specific education and training, available in buildable, modular formats, to support the primary care workforce.

Support programs, such as transition programs can assist health professionals to move into primary care were identified during consultation. However, many expressed the view that more such programs, are required across professions.

To support the development of the medical workforce, there is a clear pathway for training available to doctors completing vocational training. This provision enables GP registrars working under supervision of a GP to access a provider number and MBS rebates. This, however, does not exist for other health professions.

Consultation Example: Transition to Practice Programs

The Strength with Immersion Model Programs provided by Queensland Health support early to mid-career nurses and midwives to build their clinical knowledge and skills through clinical immersion and access to learning pathways that support career development in a range of areas including aged care, paediatrics, and community and primary care. Support is provided by mentors throughout the programs.[69]

Support for nurses who are new to primary care is available via a choice of programs offered by the Australian Primary Health Care Nurses Association. Programs include primary care specific clinical and professional learning combined with support and mentorship provided by experienced primary care nurses.[70]

Access to relevant education and training

Noting the presence of existing primary care education and training opportunities as described above, consultation highlighted many examples of the challenges faced by health professionals in accessing relevant education and training. For primary care professionals who work as sole traders, access to ongoing education and training (both formal postgraduate education programs and informal education and training opportunities) is challenging without specific support structures. Although identified as a common barrier, the inability to readily access education and training was identified as particularly challenging for health professionals working in rural and remote areas.

[67] World Health Organization (2020) Global strategy on human resources for health: Workforce 2030. Accessed 15 September 2024.
[68] NHS England (2023) NHS Long Term Workforce Plan. Accessed 20 September 2024.
[69] Queensland Health (n.d.) Strength with Immersion Model (SwIM) Programs. Accessed 10 July 2024.
[70] APNA (Australian Primary Health Care Nurses Association) Transition to Practice Programs. Accessed 10 July 2024.

"By comparison, the medical workforce has access to a range of post-graduate career development programs such as GP Rural Generalist training. If the Scope of Practice Review is to achieve its intended outcomes, workforce development programs such as the Allied Health Rural Generalist Pathway must be readily available, especially for those health professionals working in priority areas such as Aboriginal Health, Mental Health, Aged Care and, more broadly, Rural Health where they may be working across several of these areas."

Services for Australian Rural and Remote Allied Health

"The key barriers to allied health accessing ongoing education and training include a lack of funding, strategy and policy by government for allied health to access education and training pathways to advance their scope of practice."

Consultation participant, government perspective

There was a common view that improving access to flexible, responsive education and training opportunities is important for the entire workforce, including those who have achieved their professional qualification outside of Australia.

Access to support provided by a mentor, peer support and/or coach

Access to mentorship, coaching and/or peer support throughout the career continuum was viewed as important to shape and sustain the workforce, yet infrequently available. Similar to student supervision, the role of the mentor, peer support provider or professional coach was often viewed as non-essential, resulting in those who provide these services doing so without remuneration or dedicated capacity. Although established mentoring programs exist, mentorship is frequently provided in an ad hoc manner that involves health professionals seeking mentors and establishing the mentor-mentee relationships on an individual basis. Limited instances of peer support and coaching were identified in primary care.

Structured mentoring and peer support programs that incentivise participation were identified as important to secure long-term stability in the primary care workforce. A genuine desire for mentorship was identified, despite limited established programs. The potential to use the existing workforce to contribute to mentoring was viewed as potentially valuable. For example, mid-career primary care health professionals who have significant knowledge and skills but prefer to move away from direct clinical care could contribute to mentoring, should they be encouraged, permitted and supported to do so. The additional benefit of this model is the potential professional satisfaction experienced by the mentor which may contribute to workforce stability and ongoing sustainability. This workforce could also contribute to student supervision.

Establishment of communities of learning in primary care settings provide valuable support for health professionals and is a mechanism to ensure quality care through reinforcement of best practice. These communities can span service providers and may also join community members, funders and policy makers.

Similarly to pre-qualification education and training programs, quality supervision is an essential component of post-qualification education, including both formal education programs that lead to a qualification, and informal education and training. Supervision may be required to support registration of overseas qualified health professionals, for those returning to work after an absence, or completing additional education and training as part of an endorsement process or when a condition has been imposed by the National Board, panel or tribunal. In this context, Ahpra has developed a supervised practice framework and guidelines, as previously described,[71] which applies to some, but not all, health professions. Support to enable supervision in this context varies across professions.

[71] Ahpra & National Boards (2022) Supervised practice framework. Accessed 15 September 2024.

Opportunities

Several examples were provided of established mentoring programs and medical stakeholders highlighted the success of the Remote Vocational Training Scheme [72] which provides personalised supervision, mentorship and comprehensive support to assist training in rural and remote areas and First Nations communities. The Practice Incentives Program teaching payment [73] described above (see *Limited and inconsistent support for quality student supervision*) supports general practice to provide valuable training opportunities in support of the development of the primary care workforce.

Valuing (e.g., through CPD program incentives) and resourcing this type of essential support directly enables the development and maintenance of a skilled and sustainable workforce.

Consultation Example: Mentoring Programs

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists provides a mentoring program to support health professionals across all stages of their career. [74] Mentoring is rewarded through the CPD program.

The Mental Health Professionals Network [75] provides programs that specifically support interprofessional practice and collaborative care. This Australian Government funded program provides cross-professional and cross sector support by enabling mental health care providers to connect in-person and virtually, through the provision of a range of educational opportunities in webinar and podcast formats.

Access to relevant multiprofessional learning opportunities (MPL)

Enabling health professionals to learn together and engage in activities that build interprofessional relationships, particularly focused on common issues or skill development, support primary care teams to better meet community need. Learning experiences may be formal or informal. Consultation highlighted that opportunities for MPL can include health professionals who work in a range of primary care settings and should include, where relevant, health professionals who contribute to primary care from the private sector, such as non-GP medical specialists.

MPL occurs inconsistently across primary care. Although examples can be identified, including those available in rural and remote areas often across significant distances facilitated by technology, further work is needed to support and encourage opportunities for collaboration in the context of primary care teams. Recent work to broaden the inclusion of allied health professionals in PHNs [76] will likely contribute to this outcome.

The provision of relevant MPL requires dedicated and sustained resourcing. Consultation identified consistent support for the enablement of collaborative multidisciplinary teams in primary care, and for this to be incentivised through adequate resourcing combined with a fundamental commitment to collaborative team-based care.

“We are concerned that, no matter how effective the strategy, ineffective implementation will severely limit its impact. We therefore recommend that appropriate consideration be given to effective incentivisation for HCPs [Health Care Professionals] to participate in multidisciplinary care teams. We believe that a barrier to participation in SPT [Supervised Practical Training], IPE [Interprofessional Education] and MPL [Multiprofessional Learning] is health care workforce resourcing, which is likely also a barrier to participation in multidisciplinary care teams.”

Consultation participant, health service perspective

[72] RVTS (Remote Vocational Training Scheme) (n.d.) Fellowship training for doctors in rural, remote and First Nations communities. Accessed 1 August 2024.
[73] Australian Government Services Australia (2024) Practice Incentives Program Teaching Payment. Accessed 1 August 2024.
[74] Royal Australian New Zealand College of Obstetricians Gynaecologists (2024) The RANZCOG mentoring program. Accessed 10 July 2024.
[75] Mental Health Professionals Network (n.d.) Mental Health Professionals' Network. Accessed 16 July 2024.
[76] STAHF (Steering Team for Allied Health in Primary Care Engagement Framework) (2022) National PHN Allied Health in Primary Care Engagement Framework. Accessed 9 July 2024.

Education and training in rural and remote areas

Rural and remote practice requires the development of a range of skills and capabilities not routinely taught outside this setting. The scope of many rural health professionals is necessarily broad to meet the needs of the communities they serve. Consequently, rural trainees are required to develop a range of skills they would otherwise not necessarily develop. Training in rural areas commonly occurs across acute and primary care sectors, establishing skills relevant to each sector, along with an understanding of the mechanisms that support consumers as they transition between health environments. These factors combine to make rural and remote communities quality training grounds for health professions.

"Just as a dilly bag is made in and for a specific context, rural and remote multidisciplinary health teams must be created for local community context and be woven from the diverse skills of those health professionals, practitioners, students and workers who are there; just as the weavers of the dilly bag may bring in threads traded from elsewhere to finish a bag, a rural and remote multidisciplinary health team may involve external and intermittent health professionals to make it complete."

Ngayubah Gadan (Coming together) Consensus Statement: Rural and Remote Multidisciplinary Health Team [77]

Pre-professional entry programs

Despite the opportunities presented by education and training provided in rural and remote areas, a range of issues complicate or impede the ability for these communities to attract learners and provide training.

Challenges

Infrastructure to support student learning includes housing and dedicated training facilities. Most students will require accommodation to support the completion of rural and remote placement experiences, yet many rural and remote areas have limited, if any, student accommodation. When combined with poor access to student support systems, including financial support and/or temporary employment opportunities, rural and remote areas find it particularly challenging to attract students. Partnerships with government and council, small business, and local primary care providers may enable the availability of student accommodation in some areas, however, there is a need to establish sustainably resourced infrastructure including housing and dedicated training facilities for these communities.

Consultation Example: 'Teaching Towns' to facilitate rural and remote education and training

Multiprofessional student learning experiences, supported by the provision of shared accommodation, funding support and/or student employment opportunities and wrap-around community engagement, enables learners to complete their education and training while experiencing rural living. This provides many advantages, including incidental learning with and about other disciplines with a resultant impact on interprofessional collaboration, an appreciation for rural communities, and the establishment of student interprofessional networks that may continue post qualification.

Education and training provided locally. Many residents of rural and remote communities need to leave their home to complete education and training. While some return home, many do not. The establishment of training, provided within the community, enables the development of a local workforce with the added benefit of an improved likelihood that the workforce will remain in the local area. Facilitating rural education and training contributes to a sustained primary care workforce.

Remote supervision can support the provision of training in regional and remote areas, enabling students to remain in their community. Where access to digital technology is available, training can be supported by remote access to educators and trained supervisors.

[77] Australian Government Department of Health and Aged Care (2023) The Ngayubah Gadan Consensus Statement – Rural and Remote Multidisciplinary Health Teams. Accessed 15 September 2024.

Consultation Example: Marathon Health [78]

Marathon Health is a health care provider operating across New South Wales and the Australian Capital Territory via rural hubs. The service provides health care services and primary care training specifically designed to support local communities. A data driven model is used to innovate and build services around the community, using existing supports where available, to grow a sustainable workforce. By understanding the community, the team seeks to deliver health services that meet local needs.

Training across tertiary and vocational education and training sectors is provided locally, allowing community members to complete training while remaining on Country and enabling them to contribute to their community while serving as part of the rural health workforce. This model also supports program graduates to obtain employment locally, continuing the contribution to community. For example, recognising a limited mental health workforce in many communities, Marathon Health have supported First Nations community members to complete certificate qualifications through partnerships with registered training organisations and links with other mental health strategies. Approximately 30 First Nations community members have achieved qualifications and moved directly into local employment opportunities.

Accessing Australian Government funding (Department of Health and Aged Care *Addressing Critical Psychology Shortages – Supporting Provisional Psychologists to Practice* Grant), The Western New South Wales Psychology Intern Partnership supports provisional psychology students during completion of their intern training program. Using a tested, evidence-based model, Marathon Health, in partnership with two private psychology practices, provide a structured model that has proven cost and clinical effectiveness. Interns are based in, and establish connections with, the local community.

The program is designed to address the common barriers graduates who seek to work in regional areas face, including relocation and rental establishment costs and access to locally based supervision and support. Incentives are provided for interns to relocate and for supervisors who participate in the program. Support to achieve all core competencies within 12 months is provided through access to Board approved supervision, funded by Marathon Health, and Core Connect, a program developed to provide weekly training, support and connection with other interns through an established community of practice.

A total of 36 psychology interns will be supported by the program over three years, with 15 accredited supervisors contributing to this achievement.

The limited ability to attract students to rural and remote areas to complete education and training, combined with the migration of the local population to complete their qualification elsewhere, significantly impacts the availability of health professionals equipped with the skills and capabilities to provide rural and remote health care. This in turn impacts rural and remote health care and impedes the construction of effective multidisciplinary teams.

Opportunities

The Australian Government provides several programs of support for the rural health workforce through training provided in professional entry programs. The Rural Health and Multidisciplinary Training (RMHT) Program [79] provides funding to universities to deliver rural clinical training and education experiences for medical, nursing, allied health and dental students across Australia with the aim of improving recruitment and retention of health professionals in rural and remote Australia. The RMHT supports a network of 20 rural clinical schools, 19 University Departments of Rural Health (UDRH), dental schools offering extended rural placements and 28 regional training hubs based at rural clinical schools and UDRH sites. The program also supports Flinders University to operate the Northern Territory Medical Program.

The Murray-Darling Medical Schools Network (MDMSN) [80] provides five rurally based medical schools in the Murray-Darling region of New South Wales and Victoria. When fully operational, 146 graduates will join the workforce each year from this program.

[78] Marathon Health (2024) Enabling communities to thrive through health and wellbeing. Accessed 12 July 2024.
[79] Australian Government Department of Health and Aged Care (2024) Rural Health Multidisciplinary Training (RHMT) program. Accessed 12 July 2024.
[80] Australian Government Department of Health and Aged Care (2023) Murray-Darling Medical Schools Network. Accessed 12 July 2024.

In addition to the RMHT and MDMSN, the Australian Government recently committed to a range of medical workforce initiatives to enable: [81, 82]

- Up to eight new rural clinical schools
- Allocation of Commonwealth Supported Places to medical schools, including 40 new places for Charles Darwin University to establish a new medical school in the Northern Territory from 2026
- Six new medical schools, with a focus on those that provide strong training in primary care, including 80 new Commonwealth Supported Places distributed among these new programs.
- The existing Northern Territory Medical Program to provide an additional six Commonwealth Supported Places per year in addition to the 30 provided currently.

A recent evaluation of the components of effective dental and oral health training in regional areas established the key elements of quality rural placements. [83] In alignment with the views expressed by stakeholders during consultation, the findings of this evaluation suggested, among other elements, that supported accommodation and utilities, effective placement co-ordination, regular access to educators and/or supervisors with clear learning outcomes and interprofessional learning opportunities were fundamental to quality rural placements.

These findings, together with the effectiveness of established programs that support rural and remote training experiences, should be considered for their applicability to a broader cohort of professions and sites.

Post professional entry education and training in rural and remote areas

Health professionals who practise in rural and remote areas can experience unique challenges in completing education and training to support their scope of practice. Geographical and professional isolation can negatively impact rural and remote health professionals.

Communities of learning can provide a mechanism whereby health professionals are able to learn together and develop knowledge and skills relevant to their practice. However, digital connection is often required to support this multiprofessional learning, for example where health professionals are not located in the same community. Where this is not possible, professional development can be impacted, with a resultant negative impact on workforce skill, retention and sustainability.

Opportunities

A range of well-established programs support the development of rural generalist skills, such as the Rural Generalist Training Positions available through Queensland Health's Allied Health Rural Generalist Pathway [84] and the National Rural Generalist Pathway for doctors. [85] These programs provide foundational training in a broad range of skills required to support rural and remote practice for health professionals post-professional entry qualification. Flexible program delivery and dedicated supervision are features of these programs which contribute to a sustainable rural and remote health care workforce.

Several initiatives support the education and training of doctors in the post-professional entry period, including:

- The Rural Procedural Grants Program provides support to cover the costs (e.g., travel, course fees, locum cover) associated with attending professional development for procedural GPs working in rural and remote communities. Procedural GPs are entitled to up to 10 days of CPD per year.
- The General Practice Procedural Training Support Program – Anaesthetics is a scholarship program that supports participants to complete advanced rural skills training in anaesthesia.
- The Advanced Skills Training Program supports rural generalists and GPs to achieve advanced skills in regional and remote Australia and aims to increase the number of highly skilled qualified GPs and Rural Generalists available to support doctors in training.

These programs, while concentrated on delivering support for medical practitioners, provide an excellent foundation of initiatives that could serve to support other professions to complete relevant post-graduate training and CPD thereby contributing to a highly skilled, multidisciplinary primary care workforce in rural and remote areas.

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[81] Australian Government (2022) Budget October 2022–23. Accessed 1 August 2024.
[82] Australian Government (2024) Budget 2024-25: Budget Paper No. 2. Accessed 1 August 2024.
[83] KBC Australia (September 2022) Increasing Dental and Oral health training in rural and remote Australia: Feasibility study. Report commissioned by the Australian Government Department of Health and Aged Care. Accessed 12 July 2024.
[84] Queensland Government (2023) Allied Health Rural Generalist Pathway, health.qld.gov.au. Accessed 12 July 2024.
[85] Australian Government Department of Health and Aged Care (2024) National Rural Generalist Pathway. Accessed 12 July 2024.

Consultation example: Heart of Australia[86]

Heart of Australia delivers specialist, culturally safe care and diagnostic testing to rural, remote and First Nations communities in Queensland. The program, delivered by custom-designed mobile clinics, brings frontline health care to communities, enabling them to access care without needing to travel. Operating since 2014, the program has seen more than 18,000 patients, saved 800 lives and regularly served 36 communities.

In addition to providing clinical care to rural, remote and First Nations communities, the program supports health professionals by providing professional development opportunities for rural and remote GPs, nurses and pharmacists, who can access education and training opportunities without leaving their community. Heart of Australia is an accredited CPD Provider through the Royal Australian College of General Practitioners (RACGP).

Supporting the multidisciplinary primary care team in rural and remote areas

Strong multidisciplinary care teams are important to provide the health care that rural and remote communities need. Care teams may work together in the community, or be located across several communities, and are ideally tailored to comprise the specific health needs of the community. Stakeholders identified several factors that can support the rural and remote multidisciplinary health team. The following summarises these views:

- **Ensuring cultural safety.** Consumers and multidisciplinary teams were noted to benefit from culturally safe and responsive workplaces that actively and consciously eliminate racism.
- **Digital technology** was highlighted as a critical enabler of multidisciplinary teams. Links between local health professionals and specialist medical services provided in metropolitan areas were identified as critical to enable effective community-based care. For example, collaboration between rural and remote GPs and specialist medical practitioners that enables care provision in community where face-to-face consultation is not essential. This was highlighted as benefiting both the consumer and the GP, who is supported to provide optimal care locally.
- **Mentoring** was identified as a critical mechanism to support health professionals working in rural and remote areas. Supporting the team through structured mentoring was viewed as essential to combat isolation and loneliness and was noted as especially important for those team members who were not trained in Australia.
- **Co-location.** In less remote areas, multidisciplinary teams were noted to benefit from being physically located in the same space. However, in most cases, co-location would require the development of dedicated infrastructure. General practitioners expressed a clear desire to work closely with other health professionals, however noted that existing funding mechanisms fail to adequately support this model of care.

Addressing the challenges that face the development of the rural/remote primary care workforce requires a broad national reform agenda that dovetails with local community-based needs. This Review acknowledges that the recommendations made in this report will need careful tailoring to the needs of rural and remote primary care including, for example, specific mechanisms to support rural and remote education and training, as described in Recommendation 18 (see *Section D6*).

[86] Heart of Australia (2022). https://heartofaustralia.com.au/. Accessed 15 September 2024.

Supporting Interprofessional Collaboration

Primary care is delivered across a diverse range of settings, and health professionals are frequently not co-located. Collaboration across all members of the team is important to ensure safe, effective, consumer focused care. Collaborative practice *"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"*. [page 13] [87]

Interprofessional collaboration is critical to effective care. Collaboration provides an important foundation for multidisciplinary team care both within and across health sectors. This is particularly significant when consumers move between health care sectors, such as between acute and primary care. At these points, collaboration is essential to ensure consumer safety. Building a primary care workforce that fundamentally understands the importance of maintaining the primacy of the consumer, works within established relationships between health sectors (and between health and broader social sectors) and is equipped with the skills to support consumers during these transitions is critical for optimal care.

"Fragmentation in training the health workforce and the obstacles put forward by the various professional training and accreditation bodies are impediments to the proposed reforms. There is a need for training models to support the next generation of health care professionals to be able to work in multidisciplinary primary care teams where collaborative practice is the norm."

Consultation participant, education provider perspective

Supporting the professional development of primary care health professionals and developing logical shared care arrangements could enable greater collaboration within the primary care team and address workforce shortfalls. For example, upskilling GP and other health professionals to provide more specialised care, in collaboration with non-GP medical specialists.

"Currently there are large workforce shortfalls in paediatrics and psychiatry in caring (and prescribing) for these young people. This could be addressed by reform in supporting the professional development of GPs and other primary health care practitioners, investigating the effectiveness of shared care models (which have already shown some initial promise)."

Australasian Society for Developmental Paediatrics

Education providers can contribute to the development of collaborative skills through the provision of interprofessional education (IPE). In Australia, educators have provided IPE for many years and accreditation authorities specifically include accreditation standards for IPE. Quality IPE relies on effective relationships between education providers and the health sector.

Significant work, undertaken across many decades, has contributed to an understanding of IPE and its role in developing collaborative health professionals. International and Australian efforts have produced a range of tools that support the development of collaborative skills, through the provision of IPE. Competence descriptions, [88, 89, 90] practical guides [91] and learning competency statements for IPE [92] are available.

Recent work, undertaken by Ahpra and the Health Professions Accreditation Collaborative (HPAC) Forum has contributed to an enhanced focus on IPE in education programs. The Ahpra Accreditation Committee has developed an interprofessional collaborative practice statement of intent [93] which seeks to embed interprofessional collaborative practice across

[87] World Health Organization (2010) Framework for action on interprofessional education and collaborative practice. Accessed 10 July 2024.
[88] CIHC (Canadian Interprofessional Health Collaborative) (2024) CIHC Competency Framework for Advancing Collaboration. CIHC website. Accessed 09 July 2024.
[89] EIPEN (European Interprofessional Practice & Education Network) (2021) The EIPEN key competences for interprofessional collaboration. Accessed 9 July 2024.
[90] IPEC (Interprofessional Education Collaborative) (November 2023) IPEC Core Competencies for Interprofessional Collaborative Practice, Version 3. Accessed 10 July 2024.
[91] Ford J, Gray R. (2021) Interprofessional Education Handbook: For educators and practitioners incorporating integrated care and values-based practice. CAIPE Publications: Centre for the Advancement of Interprofessional Education (CAIPE); 2021.
[92] O'Keefe M, Henderson A, Chick R. (2017) Defining a set of common interprofessional learning competencies for health profession students. Medical Teacher. 39(5):463-8
[93] Ahpra & National Boards (2024) Interprofessional Collaborative Practice Statement of Intent. Accessed 9 July 2024.

health care settings, to contribute to co-ordinated care and optimised outcomes for service users.

The HPAC Forum has completed research focused on improving the provision of IPE across health professions.[94, 95] This research recommends an improved collaboration between Forum members in accreditation processes and the development of a curriculum framework for IPE in Australia. This recent work builds on several initiatives undertaken by the Forum, including development of a position statement on IPE[96] and a survey of members that described accreditation practices related to IPE.[97]

Greater consistency in accreditation processes for IPE was identified by Professor Michael Woods in his review of accreditation systems within the NRAS, in which he suggested the need for *"a common, cross-professional approach to the active support for interprofessional education in all accreditation standards and assessments."* [page 3][98]

However, aligned with published literature, consultation completed as part of this Review highlighted that education providers experience significant challenges in providing quality IPE. Frequently, educators described difficulties in resourcing, developing, scheduling, delivering and assessing IPE experiences. Consequently, inconsistencies can be observed between professions in the provision of IPE. Consultation highlighted a common view that there is a need to further develop and endorse a shared vision of collaborative capability and establish common principles to support the design and development of IPE in pre-professional entry programs.

"...as well as 'learning together', health professional students can learn much from the varied professions. Especially in primary care and other community-based settings, this is not well supported by policies and funding mechanisms. For example, the guidelines for the Practice Incentive Payment that supports the teaching and training of medical students in primary care only applies when the teaching session is 'given by a GP'. This ignores the valuable learning opportunities for medical students to experience, learn and contribute to, for example, a nurse-led child health clinic, pharmacists' medication management, psychologists' mental health services."

Medical Deans Australia and New Zealand

In the context of primary care practice, multiprofessional learning can contribute to greater collaboration within the multidisciplinary team. Learning together, either in a face-to-face context or remotely, has the potential to remove cross-professional barriers and enable improved collaboration and team-based care.

Advocacy for the multidisciplinary team is important for both students and health professionals. Learning to recognise, understand and trust the skills and capabilities of other professions is an important foundation for effective interprofessional collaboration.

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[94] Health Professions Accreditation Collaborative (HPAC) Forum (2024) Developing a collaborative health practitioner through strengthened accreditation processes. Accessed 20 September 2024.
[95] Kent F, Cardiff L, Clark B, Gustavs J, Jolly B, Maundu J, et al. (2024) Accreditation as a lever for change in the development of the collaborative practitioner in the Australian health system. Australian Health Review. https://doi.org/10.1071/AH24165.
[96] Health Professions Accreditation Collaborative (HPAC) Forum (2018) Position statement on interprofessional education. Accessed 9 July 2024.
[97] Health Professions Accreditation Collaborative (HPAC) Forum (2020) Interprofessional Education (IPE): Report on the findings of a survey of HPAC Forum members. Accessed 9 July 2024
[98] Woods M (2017) Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions - draft report. Accessed 20 September 2024.

Interdependencies

The issues raised in this theme are frequently interconnected, which impacts the reform process. Addressing one issue may fail to result in an effective outcome where additional unresolved issues exist. For example, developing a highly skilled and available supervisor workforce will be unable to support primary care health professional development where financially viable partnerships between education providers and primary care providers remain unavailable. Similarly, multiprofessional learning and team function could be enhanced by greater visibility of the skills and capabilities of the multidisciplinary team as described by the proposed National Skills and Capabilities Framework and Matrix (see *Section* A1).

Addressing inconsistencies

As described throughout this section, a range of inconsistencies exist within primary care that impact workforce development and capability. Several established workforce development initiatives specifically focus on developing the medical workforce, which is essential. However, many professions are experiencing workforce pressures and could benefit from similar support mechanisms.

Enabling equity in access to existing essential programs that support students to participate in education and training, facilitate quality supervision, support primary care health professionals to engage in supervision and enable access to ongoing education, training, mentoring and transition programs are essential factors in the development and maintenance of a stable and sustainable primary care workforce. Building the entire primary care workforce and enabling all health professions to access the support they need to continually develop professionally is consistent with the premise that a highly functional multidisciplinary primary care workforce benefits community.

"A profound culture shift is needed across government and the health sector to ensure the voices of the entire health care community are heard and to drive the enablement of genuine multidisciplinary care teams working to full scope."

Dietitians Australia

Clear articulation of the expectations for primary care practice, including professional capabilities, can contribute to the design, development and delivery of quality education and training. While many professions have developed primary care practice expectations, others have not and should be supported to do so. Furthermore, clearly defining the required capabilities for collaborative practice and First Nations health care is important to support development of the primary care workforce.

Policy direction in relation to accreditation authorities

Under the National Law, HMM can give policy direction to National Boards on matters across their remit, consistent with the full range of objectives of the legislation. However, in relation to accreditation functions, HMM's policy direction power is significantly limited by the law. While policy direction can be given on any matter relevant to the policies, process or procedures of a National Board, section 11.4 (a) and (b) specifies that policy direction can only be given to a National Board on particular proposed accreditation standard and only if –

A. in the Ministerial Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health professionals; and
B. the Ministerial Council has first given consideration to the potential impact of the Council's direction on the quality and safety of health care.

This limitation is unnecessarily restrictive and is inconsistent with the HMM's broad policy role and remit with other functions of the Boards. It serves to potentially restrict the ability of Health Ministers to exercise the full range of policy direction, in particular in the accreditation functions outside of the two permissible conditions above (S11.4 a & b). A number of the proposed reforms in this Review have a broader objective than permitted under S 11:4 (a) and HMM should not be unnecessarily restricted in progressing the reforms.

The Review acknowledges the considerable work currently underway to review the complexity of the NRAS. In its first consultation paper [99], the *Review of complexity in the National Registration and Accreditation Scheme (September 2024)* has highlighted the challenge of achieving strategic alignment between health workforce regulation, planning and development and the expectations of Ministers. This misalignment has been specifically identified in the context of accreditation and further work in this area may impact the intended outcome of the recommendations made as part of this Review. However, addressing this issue would enable an improved alignment between policy direction and education, allowing educators to more effectively respond to changes in consumer need and professional practice.

Health professionals will have the skills and capabilities they need to provide care that aligns with the policy directions of government so that education programs can better respond to changes in consumer need and professional practice.

Primary care workforce development program

To support the development and retention of a skilled, stable and collaborative primary care workforce, a national **primary care workforce development program** is proposed in conjunction with the removal of barriers to primary care education and training. The proposed program would comprise three streams of support which would, together, address the persistent challenges to workforce training identified during consultation.

To be effective, the program will require removal of existing barriers to education and training. This should include amendment of MBS billing rules to recognise that a pre-qualification student may be involved in delivering part of a service under the supervision on an eligible practitioner.

The NHRA mid-term review highlights a need to strengthen endeavours that support the health care workforce. [100] The program would provide a substantial opportunity to support the primary care health workforce.

Objectives of the program

The program will deliver initiatives that support the student, the supervisor and primary care health professionals through the establishment of:

- Dedicated practical training in primary care, consistent with community need
- A clear vision of collaboration and a consistent approach to developing collaborative skills
- Supported equitable access to resources, including dedicated and trained supervision for student placements across all professions
- Resources to support dedicated quality supervision and mentoring for all professions
- Expanded rural and remote training initiatives across additional areas and professions.

Program Stream 1: The Student

Objective: To support quality primary care education and training experiences in pre-professional entry programs.

Mechanisms:

- Enable equitable support for all health professionals to experience quality supervised education and training in primary care through an extension or enhancement of existing programs (e.g., Prac Payment scheme), or the establishment of new multidisciplinary programs for student placements. Eligibility to access support should be non-competitive and based on enrolment in an accredited health professional program and available to all disciplines who work in the primary care sector. Equitable program support would enable students to relocate and access accommodation in rural areas while engaging in placement experiences. Specific support should be made available for students to travel to rural and remote areas.
- Establish agreed principles for collaborative practice and the development of professional capabilities for regulated and self-regulated professions, building on work previously completed by Ahpra and the HPAC Forum. This should be reflected in the respective accreditation standards in the NRAS. Similar professional capabilities could be adopted by health professions regulated outside of the NRAS.

[99] Australian Government Department of Health and Aged Care (2024) Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Accessed 20 September 2024.
[100] Australian Government Department of Health and Aged Care (2023) Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report. Accessed 18 July 2024.

Program Stream 2: The Supervisor and Mentor

Objective: To support the vital role of supervisors and mentors in workforce development and contribute to the development and retention of a quality supervisor/mentor workforce.

Mechanisms:

- Enable equitable training and support for supervisors and mentors across all disciplines to support quality education and training experiences in primary care through an extension or enhancement of existing programs that provide supervisor and/or mentor training (e.g., the Remote Vocational Training Program) or the establishment of new multidisciplinary programs for supervision and/or mentorship. Eligibility to access support should be non-competitive and reflective of current role. Support would enable capacity building within the workforce and education, training and specific support for mentors and supervisors.
- Develop new and/or adopt existing goals for supervision across professions, including for cross-professional supervision.
- Ensure all eligible primary care health professionals are not unnecessarily restricted by MBS rules from supervising students during primary care consultations. This could be achieved through reviewing and harmonising MBS funding rules across professions as described above.
- Establishing clear principles and professional capabilities for collaborative practice, as described in Program Stream 1, would also support the supervisor and mentor.

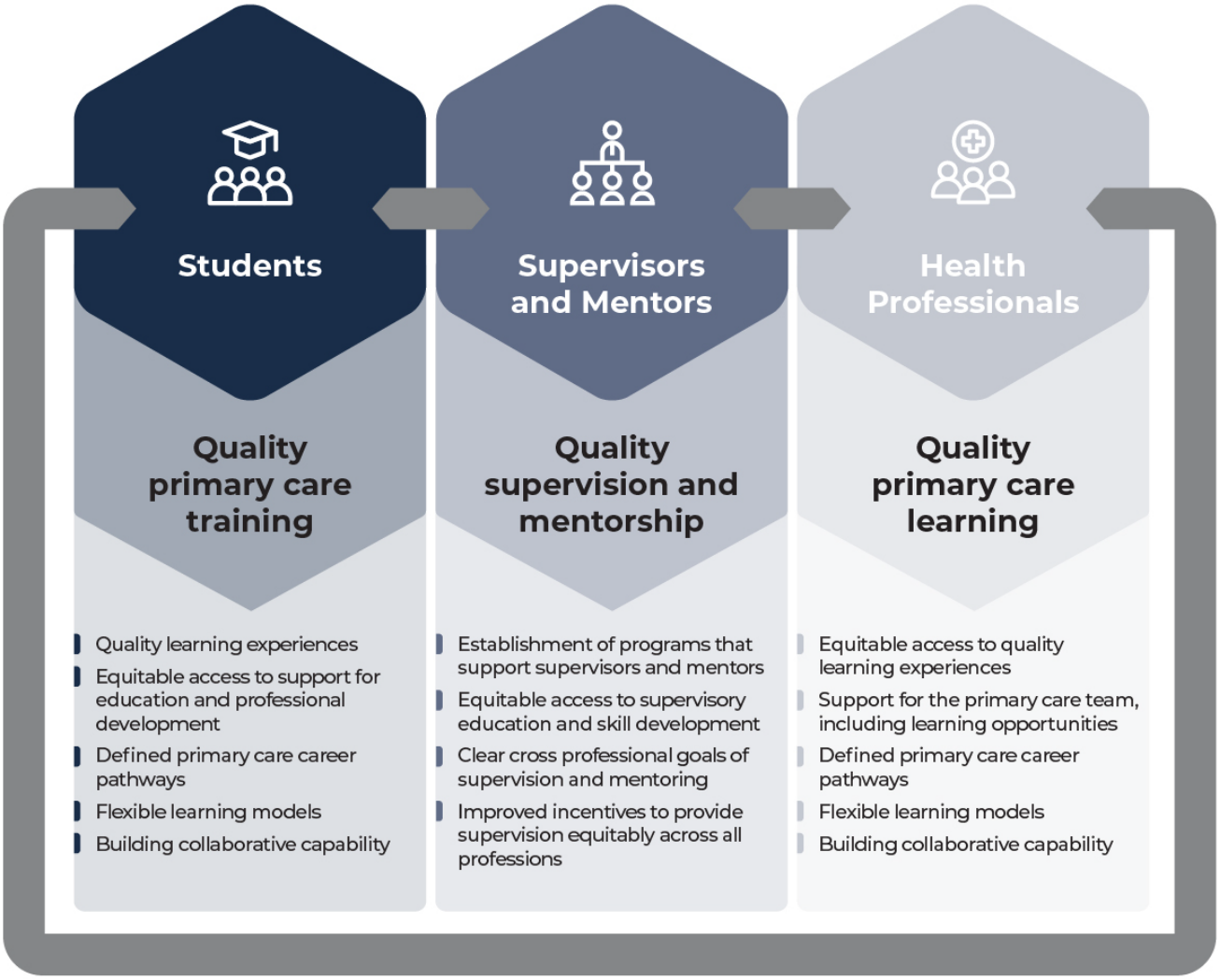
Program Stream 3: The Primary Care Health Professional

Objective: To support the ongoing development and retention of a highly skilled primary care workforce.

Mechanisms:

- Enable primary care health professionals to access and complete post-qualification education and training in areas of clinical care and primary care business development through an extension or enhancement of existing programs (e.g., Rural Generalist Training Program) or the establishment of new multidisciplinary programs for post professional entry education and training.
- Enable the development and provision of accessible, authentic opportunities for MPL, including via primary care networks.
- Extend and/or develop and provide transition to practice programs for primary care, to support workforce mobility across services and settings.

Figure 7 Overview of the proposed primary care workforce development program



Program outcomes

The program would support a longitudinal view of the development of the primary care workforce, link with a range of existing initiatives and focus on ensuring stability and sustainability in the workforce.

Overall outcomes for the program include a positive change in culture and society to recognise and value the vital role of primary care within the broader health system and equitable access to support for all primary care health professionals.

Student outcomes

- Improved visibility of primary care early in pre-entry programs through quality learning experiences, including supervised placement learning in a range of primary care settings.
- Structured and consistent development of collaborative practice skills according to defined outcomes applicable across professions.
- Support to complete quality placement experiences, including in rural and remote areas.

Supervisor/mentor outcomes

- The development, recognition and support for supervisors that provide pre-professional entry education and training across all professions and support for mentors and peer support providers who contribute to health professional development.
- Support to establish quality learning environments, including consultation rooms and spaces equipped to support practical training and development.
- Improved incentives to provide supervision equitably across all professions.

Health professional outcomes

- Removal of structural barriers that disincentivise primary care health professionals from supporting student practical training, and artefacts that prevent cross-professional supervision and training.
- Access to education and training that supports practice scope, including MPL opportunities and transition programs for primary care.

Benefits of the program

This program would benefit a range of stakeholders, including:

- **Consumers and communities** would benefit from a strengthened primary care workforce, including rural, remote and First Nations communities.
- **Students** would be supported to undertake supervised placement learning in primary care with the resultant development of an improved understanding of their role in primary care and development of the skills necessary to practice in this setting.
- **Health professionals** would benefit from improved opportunities to develop primary care skill and capability and to receive and provide mentorship and/or peer support.
- **Supervisors** would be recognised and supported for the important role they contribute to health professional development and enabled to support the role and create capacity within their workday to comprehensively contribute to the role.
- **Mentors** would be recognised and supported for their contribution to health professional development and the retention of fulfilled staff.
- **Primary care multidisciplinary teams** would benefit from opportunities to learn together and develop communities of practice to support primary care.
- **Employers and health services** would benefit from a highly skilled and sustainable workforce.
- **Education providers** would be able to establish additional partnerships with primary care and develop curricula that include an enhanced focus on primary care, where these do not currently exist.
- **Accreditation authorities** would be supported in their assessment of education programs by standards that specifically relate to primary care and First Nations health care teaching and learning and the development of collaborative capability consistent with a shared interprofessional vision.
- **Professional organisations** could collaborate with education providers to develop curricula that support primary care skill development, where this does not already exist.
- **PHNs** could contribute to MPL, by providing opportunities for local primary care teams to learn together about common issues.

Program governance

Governance for the proposed program will lie with the Australian Government and will require engagement with a broad range of stakeholders to support development, implementation and evaluation. PHNs, with appropriate capacity uplift, could provide implementation support for the programs at the regional and local level.

Given the acknowledged complex relationships between workforce development, including all aspects of education, training and professional development, and health service need, reforms in this area will require carefully considered and structured research, monitoring and review to ensure the desired outcomes are achieved and no unintended consequences are observed.

Impact on multidisciplinary care teams

A structured, well-resourced approach to the development, maintenance and enhancement of the primary care workforce would enable the multidisciplinary team to provide quality care.

Interprofessional respect, trust and cohesiveness would be supported by enhanced IPE and MPL experiences, supported by incentives.

The removal of current inequities would break down professional siloes, for the benefit of the team, while learning together benefits the team by supporting interprofessional respect and understanding.

Enablers

Implementation of the proposed reforms would be enabled by (and would enable) the establishment of additional or strengthened **partnerships between primary care practices and education providers**, noting that for some professions these already exist. To support quality education and training, clear expectations about practical training outcomes and supervision should be defined and agreed between parties.

Co-design of practical training/placement experiences with consumers and First Nations peoples would support the provision of authentic training experiences and the development of essential primary care skills.

A cultural shift away from supervision and mentoring as 'add on' activities completed in addition to existing workloads, to recognise and value the importance of the role in the context of developing the primary care workforce. Recognition of supervisory skills and qualifications in the proposed National Skills and Capability Framework and Matrix would contribute to this aim (see *Section A1*).

The **availability of quality, relevant and accessible MPL experiences** would enable the primary care team to learn together for the benefit of the community.

The recently released Australian Universities Accord[101] highlights a range of issues affecting higher education and provides a vision for a more 'equitable and innovative' higher education system. The Accord supports education and training provided in regional areas and recommends improvements to funding arrangements that enable equitable student support to complete education. Implementation of these recommendations would contribute to the outcomes of this area of reform.

Nationally consistent recognition of health professional skills and capabilities would facilitate improved workforce retention, flexibility and mobility. Development of the National Skills and Capability Framework and Matrix, in parallel with the National Skills Passport[102] would contribute to this aim (see *Section A1*).

The National Skills and Capability Framework and Matrix would contribute overall to cross-jurisdictional recognition of primary care skills and capabilities. This will support the primary care workforce and enable greater mobility within the workforce.

[101] Australian Government Department of Education (2024) Australian Universities Accord. Accessed 22 July 2024.
[102] Australian Government Department of Education (2024) National Skills Passport Consultation Paper. Accessed 22 July 2024.

Recommendations

Recommendation 2: The Australian Government establish a primary care workforce development program to support the development and retention of a skilled, stable and collaborative primary care workforce through the provision of enhanced curriculum, training/placement and career development capacities for students, supervisors/mentors and primary care health professionals.

Recommendation 3: The Health Ministers' Meeting (HMM) agree amendments to the National Law to provide a consistent authority of the HMM to give policy directions to the Australian Health Practitioner Regulation Agency (Ahpra) and National Boards in both registration and accreditation functions.

Recommendation 4: Develop principles for Interprofessional Education (IPE) and interprofessional capabilities for primary care, collaborative practice and First Nations health care to contribute to contemporary and consistent cross-professional learning and practice.

4.1 The Health Ministers' Meeting (HMM) request accreditation authorities and National Boards reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant Continuing Professional Development (CPD) guidelines and requirements.

4.2 Professional organisations for self-regulated professions reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant CPD requirements.

Recommendation 5: Remove unnecessary barriers to supervision in primary care education and training, including those that impede cross-professional supervision.

5.1 The Health Ministers' Meeting (HMM) request National Boards and accreditation authorities enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.

5.2 Professional associations for self-regulated health professions enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.

5.3 The Australian Government review Medicare Benefits Schedule (MBS) rules and guidelines to ensure that all health professions are reasonably and equitably supported to undertake workplace-based placement supervision in primary care.

Implementation

Implementation of the proposed reforms will require the following steps.

- **Complete a comprehensive stocktake and scoping of relevant existing programs**, resources and activities that could be expanded, reshaped, streamlined or aligned to support the reforms, including, but not limited to, supervisor training programs and frameworks, mentorship and peer support, the establishment of optimal learning environments and accreditation of quality training sites, IPE descriptions and guidelines, transition to practice programs and examples of community-driven MPL. **(Short-term)**
- **Engage with stakeholder organisations** necessary to facilitate reforms and/or provide valuable learnings to shape the reforms, including but not limited to, consumers, PHNs, continuing education and professional development providers, education providers, accreditation authorities, professional associations, primary care professionals, employers, regulators and insurers. **(Short-term)**
- **HMM agree to the amendments to the National Law** to provide a consistent authority of the HMM to give policy directions to Ahpra and National Boards in both registration and accreditation functions. This could be achieved by deleting Part 2,11 Policy Directions, Sections 11.4 (a) & (b) which is unnecessarily restrictive. **(Short-term)**
- **Engage with stakeholders to commence a review of MBS rules** that govern access to payments for health professionals who provide supervision to students in primary care. This would require a comprehensive review and amendment of relevant sections of the *Health Insurance Act* and determinations to enable access to payments for consultations that include direct care provided by a student. **(Short-term)**

Theme B: Legislation and regulation

Two reform proposals are presented below relating to legislation and regulation:

B1. Initiate a more balanced and consistent approach to regulating scope of practice which supports primary care professions equitably

B2. Independent, evidence-based support for health workforce innovation, access and productivity

B1. Initiate a more balanced and consistent approach to regulating scope of practice which supports primary care professions equitably

Summary

Legislation and regulation shape the authorising environment which informs health professionals' ability to work to their full scope of practice. Primary care is delivered by a wide range of health professions, who are broadly grouped based on their means of regulation through one of three mechanisms:

- Registered professions are regulated under the NRAS
- Non-registered professions are not regulated under the NRAS, who consist of the following:
    - Self-regulated professions, who are regulated by profession-specific colleges and associations
    - Other non-registered professions (e.g. health assistants, technicians, care workers, and peer support workers), who are regulated according to a range of legislation and jurisdiction based regulatory processes.

In Australia, 16 health professions are registered and regulated under the NRAS enacted by the National Law. All other health professions which make up the primary care workforce, including many allied health professionals, are not regulated under the NRAS, and are instead governed by a range of laws and localised clinical governance arrangements which together ensure quality and safe care is delivered.

Broadly, the legislative and regulatory landscape serves its intended purpose in terms of protection of public safety, and evidence heard through this Review indicates the NRAS and the National Law are broadly working to their enabling intent. However, there are barriers within the broader legislative and regulatory landscape (outside of the NRAS) which prevent health professionals from performing activities within their scope of practice in circumstances where it would be safe to do so. There are various ways in which scope of practice is impacted by legislation and regulation. The sum of evidence heard through this Review points to four main issues:

- Commonwealth, State and Territory government legislation and regulatory instruments (unrelated to the NRAS) are prescriptive 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. This is primarily through reference to protected titles, including 'shorthand reference' to the National Law, and has the impact of disallowing professions who are not named from carrying out the relevant activities, even when they otherwise fall within their scope of practice.
- Self-regulated professions experience particular barriers to working to their full scope of practice due to their self-regulated status, which automatically excludes them from the wide range of legislation or regulations which make shorthand reference to the National Law (as above).
- Because of this level of specificity, there is a high degree of rigidity in the legislative and regulatory environment which acts as a barrier to reflecting emerging or changing best practice. This means the primary care system is at times unable to keep pace with how people want to deliver or to receive care.
- Many subjects are legislated or regulated differently across States and Territories. Legislative and regulatory instruments lack definitional consistency and clarity across jurisdictions. This has the impact of restricting health professional mobility, skills portability and consumer access to care.

These overlapping issues restricting scope of practice in primary care call for a multi-layered program of legislative and regulatory change to be progressed. The reform agenda should consider both existing and future legislation and regulation, to address priority issues embedded in current legislation and regulation while avoiding the same issues being replicated in future legislation and regulation. The core elements proposed below are detailed in greater depth throughout this section:

- Implement activity-based regulation of scope of practice to complement protection of title approaches, in relation to specific clinical activities.
- Apply the activity-based regulatory approach to future legislative and regulatory instruments, and limit references to protected title to only those circumstances where it is necessary to protect public safety.
- Review and harmonise existing legislation and regulation which contain unnecessarily restrictive application of shorthand references to protected titles, and where there is significant inconsistency between jurisdictions in how the legislation and regulation is written or applied.
- Enable self-regulated professions to operate at full scope of practice through targeted legislative amendments to remove existing barriers.

Activity-based regulation to complement protection of title approaches

Professional titles reflect the standards and practice expectations that underpin registration and contribute to the recognition of a profession's scope, and it is an offence to use a protected professional title without achieving necessary registration. While Australian legislative and regulatory mechanisms which apply a 'named profession' or 'protected title' approach to regulating scope have generally served Australia well in terms of protection of public safety, there are 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. Stakeholders representing a range of primary care professions described circumstances where this approach restricts their scope of practice, because referring to protected titles does not reflect all instances where health professionals are qualified, trained and competent to perform particular activities.

The most widespread regulatory issue emerging from a targeted legislative review undertaken as part of this Review was the ubiquity of shorthand references to the National Law in legislation and regulation which indirectly regulates scope of practice in primary care, such as Drugs and Poisons Acts, Radiation Safety Acts and Mental Health Acts.[103] The main negative impact of this is the exclusion of health professionals (such as self-regulated professionals) who are not regulated under the NRAS. This was found to have a significant and material impact on these health professionals' ability to work to their full scope of practice.

While professional title recognition is highlighted as an important regulatory mechanism to maintain into the future, a complementary approach that focuses on specific activities which are mapped to health professional capability is therefore suggested. This 'activity based' or 'risk based' approach recognises the capabilities of all health professions, rather than only those who are regulated, by identifying which health professions have the proven capability to provide a particular activity. Activity-based regulation (ABR) exists in practice in other national jurisdictions, taking various approaches as highlighted in the literature and evidence review undertaken to support this Review, and detailed below. ABR is based on the inherent risk involved in delivering an activity, rather than reliance on an externally defined protected title.

[103] Legislation which directly regulates scope of practice (meaning the object of the regulatory instrument is to regulate scope of practice) is differentiated from regulation which indirectly regulates scope of practice (i.e., the object of the regulatory instrument is not to directly regulate scope of practice, but nevertheless has an impact on scope of practice, for example drugs and poisons legislation).

How do international jurisdictions regulate risk-based scope?

Canada: Regulation of health professionals occurs through each of the provinces and there is no National Scheme. There has been a move away from traditional regulation models towards 'umbrella frameworks' characterised by overlapping scopes of practice and recognition of skill and capability, rather than title. Umbrella frameworks introduce regulatory flexibility and loosen unnecessary restrictions on scope of practice. This model better enables a collaborative care model making substitution possible where appropriate in cases of overlapping scope. Nova Scotia has additionally introduced consolidated legislation for 21 self-regulated health care professions and will make self-regulating professionals members of a 'Network' to facilitate 'opt-in' collaboration.

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

United Kingdom: Regulation of health professionals is undertaken by 10 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. The Professional Standards Authority for Health and Social Care (PSA) has oversight over these regulatory bodies. The PSA also plays an external accreditation and certification role over a series of voluntary registers maintained by professional bodies.

These examples highlight that implementation of ABR is an approach with relevance for scope of practice globally, and that ABR can occur in several ways. It is not the intention of this Review to suggest implementation of an umbrella framework per se, rather to propose that ABR be applied as an approach to addressing specific regulatory and legislative barriers, to complement ongoing title protection. Decisions regarding the implementation of ABR in Australia would be undertaken by governments, Ahpra and National Boards, and other relevant key stakeholders, based on identified priority practice areas and the stakeholder who has responsibility or jurisdiction over these.

As noted above, the role of the NRAS in health system stewardship is significant. Consistent with the objectives of the Scheme, this Review seeks to enable better use of the primary care workforce. Alongside professional title protection, ABR could serve to both recognise and enable health professionals to more effectively use their proven skills and capabilities, aligning with NRAS objectives around workforce mobility, access to services and system innovation. However, it should be noted that a key feature of ABR would be to provide an avenue to enable non-registered health professionals to practise to their full scope, as detailed further below.

Objectives of the NRAS[104]

The objectives of the NRAS are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and *Schedule Health Practitioner Regulation National Law Act 2009* Current as at 1 July 2024 Page 67 Authorised by the Parliamentary Counsel

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction

(c) to facilitate the provision of high-quality education and training of health practitioners

(ca) to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners

(e) to facilitate access to services provided by health practitioners in accordance with the public interest

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

[104] Australian Government. Health Practitioner Regulation National Law Section 3 (2) [a-f].

Incorporating a complementary ABR approach to ongoing title protection is proposed to be implemented through several key avenues addressing specific issues embedded in the Australian legislative and regulatory environment.

The specific area of reform to which an ABR approach is considered by this Review to have the most material impact is in addressing an over-reliance on references to protected titles in select areas of legislation and regulation outside the National Law arrangements. The proposed steps, as outlined across the remainder of this section, are:

1. Identification of those activities which would benefit from an ABR approach
2. Based on the above selection, application of the activity-based approach to **future** legislation and regulation to avoid unnecessary references to protected titles
3. In parallel, review and potential harmonisation of existing legislation and regulation for shorthand reference to protected titles.

Selection of in-scope activities

Implementation of activity-based regulation could be focused in different ways. Issues Paper 2 proposed focusing initially on higher-risk activities shared across multiple professions. However, broad stakeholder responses to this proposal emphasised that focusing on higher-volume activities which are commonly shared across professions, which may or may not be higher-risk, would have relatively greater impact in meeting community need.

Therefore, the proposed focus is on activities which:

- Are effectively common or shared across a number of health professions, or have the potential to be, and
- Meet an appropriate risk threshold, and/or
- Are novel clinical activities not currently performed or undertaken only by a single discipline, and
- are in the public interest consistent with the objectives of the National Law, S3 (2) [a-f].

It is noted that the reference to NRAS objectives does not imply the regulated activities will be limited to only those professions regulated under the NRAS. In fact, a key rationale for an ABR approach is in addressing scope of practice barriers for self-regulated professions, who fall outside the NRAS.

ABR in relation to prescribing

An example of a shared activity for which a range of professions have proven competence is the prescribing of medicines. Australia has been proactive in developing a nationally agreed set of prescribing competencies that apply to all prescribers. Many professions reference these competencies in their relevant practice standards and/or accreditation standards for education programs. Through the prescribing competencies, health professionals may achieve prescribing competence, yet be prevented from prescribing due to inconsistencies in jurisdictional based legislation and/or regulation, which are beyond the remit of the NRAS and work in contrast to its enabling intent.

Addressing this issue would require both regulatory and legislative change which applies an ABR approach. In this instance, a key issue is that drugs and poisons legislation across jurisdictions is highly specific about which named professions can perform prescribing activities.

Review and potential harmonisation of drugs and poisons legislation would apply an ABR lens by removing these references to protected titles as appropriate, and instead referring to professions who are competent, trained and authorised to perform the activity (i.e. as defined by nationally agreed competencies), remaining silent on specific professions. A proposed approach to harmonisation of drugs and poisons legislation, consistent with the above, is outlined further in this section.

Following this example, other focus areas should be selected for an activity-based regulatory approach. One entity who could perform this activity identification and prioritisation role is Ahpra and the National Boards (working with key relevant stakeholders), in recognition of their existing leadership in primary care system regulation. The Independent Mechanism proposed in *Section B2* may also play a role as this identification and prioritisation relates to emerging and models of care and innovative uses of the primary care workforce. Finally, governments will perform a role because potential focus areas for prioritisation overlap with activities over which governments have jurisdiction.

Apply the activity-based approach to future legislation and regulation to avoid unnecessary references to protected titles

Consideration should be given to an activity-based approach to any future legislation and regulation that impacts on scope of practice. This means that consideration should be given to applying the activity-based approach to future legislation and regulation where appropriate, as a complement to title protection. Without firm intergovernmental commitment to consider and implement an activity-based approach as a complement to the title protection-based approach, where appropriate, the same issues restricting scope of practice will proliferate in future legislation and regulation.

"Risk-based regulatory approaches are likely to be more appropriate than current approaches that rely on the National Law to the exclusion of self-regulated health professionals in enabling all health professions to work to full scope of practice. This is likely to be particularly important where there is overlapping scope of practice, skills and capabilities (e.g. Orthoptics, Ophthalmology, Optometry) to enable all health professionals with necessary capabilities to perform these activities. It will be essential that all health professions are included where relevant, beyond those registered with NRAS."

Orthoptics Australia

The reliance on shorthand references to protected titles also unintentionally excludes emerging models of care and health professions. Where legislative and regulatory instruments are unnecessarily prescriptive about which professions can deliver certain activities, this acts as barrier to full scope of practice in two key circumstances:

- Where the scope of a profession or the workforce model evolves over time to include that activity, for example a paramedic working in the community rather than from an ambulance;
- In the case of emerging professions that can deliver that activity within their scope, for example Nurse Practitioners, or members of the Aboriginal and Torres Strait Islander health workforce who provide vaccinations.

A commitment to a more balanced approach to regulating scope of practice, which does not rely solely on title protection, in future legislation and regulation would help to address the high degree of rigidity within the legislative and regulatory environment. This would help to make the primary care system more responsive to innovation and new evidence which may arise in the future.

"Clarifying and simplifying legislative definitions that currently act as barriers is necessary, but this is a significant and intricate challenge. For example, emerging roles such as nurse practitioners and community paramedics are often constrained by perspective-bound legislation and may not be explicitly named."

Consultation participant

"In a rural context we don't have many [health providers]. It is about making sure the people you do have there are trained and able to provide services to consumers. I'd trial [the activity-based approach] in a rural/remote setting... more competency-based, demonstrating people are doing the same thing across different professions, as long as it's properly assessed."

Consultation participant, rural and remote perspective

Governments, by committing to a more equitable and effective approach which seeks to enable all professions to work to their full scope through a focus on activity rather than solely on title, except in circumstances where it is necessary to recognise title to protect public safety, would communicate a commitment to better reflect health professionals' genuine scope of practice into legislation and regulation. This means that prioritised areas of legislation and regulation would create an authorising environment more in line with what current and emerging primary care professions can safely undertake.

Further examples of challenges brought about by existing references to protected title in legislation and regulation include where shorthand references prohibit activities from being carried out in situations where the named profession(s) are not physically present. This has particular impact in rural and remote settings that are operating in an environment of scarce workforce availability, where having a specific profession present at all times is not realistic, and where reliance on remote supervision is more common.

Review and potential harmonisation of existing legislation and regulation for shorthand reference to protected titles

Further to the approach of focusing on future legislation and regulation as described above, existing legislation and regulation should be subject to review in applying an ABR approach. As discussed above, there is a significant volume of existing legislation and regulation, which regulate specific aspects of scope of practice (i.e. specific activities relating to a certain subject of legislation), which make shorthand reference to protected titles. Prominent examples of shorthand references that unnecessarily restrict scope of practice were identified through the targeted legislative scan undertaken as part of this Review. Moreover, these shorthand references do not correspond to consistent definitions across legislation and regulation nor across jurisdictions.

It is proposed that a more comprehensive, retrospective review and harmonisation of legislation and regulation should be undertaken, initially focusing on areas with the potential to most materially impact scope of practice. Specific areas of legislation and regulation were emphasised strongly throughout the course of this Review as sensible starting points for a potential larger body of work to harmonise legislative approaches and progress a move to activity-based regulation.

"Different State and Territory regulations have significant impact on professions being able to practice to their full scope, and extend their scope if wanted. It often results in professionals choosing not to work in a specific jurisdiction if it means their scope is restricted."

Consultation participant, peak organisation perspective

Drugs and Poisons legislation, which exists as separate legislation in each State and Territory, comprises a prominent subject matter with a material impact on health professionals' ability to work to full scope of practice. A review of drugs and poisons legislation found that across States and Territories, references to 'a practitioner' or equivalent had the effect of excluding professions not designated as practitioners under the National Law. While this may have been done with the intention of limiting activities (such as prescribing and dispensing) to specific professions with these activities within their scope of practice, it simultaneously restricts the scope of practice of health professions, particularly self-regulated professions, in carrying out these activities where appropriate.

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.

The regulatory review, along with stakeholder evidence, indicates that the same set of issues that limit health professionals working to their full scope of practice in drugs and poisons legislation are pervasive in other legislative and regulatory instruments. Two areas particularly identified during consultation as being subject to these limitations are **mental health** and **radiation safety**. That is, within these subjects of legislation, scope of practice is also limited through the use of named professions.

Harmonisation of legislation and regulation to address broader definitional issues

Scope is also limited by inconsistent definitions across jurisdictional legislation which would need to be resolved through a process of harmonisation. That is, there are further definitional issues across State and Territory legislation and regulation which will not be addressed by the removal of unnecessary references to protected titles alone. This broader lack of definitional clarity between jurisdictions, which stems from the federated nature of State and Territory legislation, would require a broader harmonisation agenda to be fully considered and implemented. An example of how this manifests in drugs and poisons legislation is illustrated below.

Insights from legislative and regulatory review

A review of all State and Territory drugs and poisons legislation highlighted significant definitional inconsistency in the following areas.

- In relation to definitions of who can carry out legislated activities (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.
- In the definitions of the activities themselves (i.e. 'supply', 'dispense', 'sell', 'deal with') are each used across various Acts to refer to overlapping conceptualisations of activities relating to the provision of medicines.

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.

Legislative harmonisation is a complex and significant undertaking requiring high degrees of long-term commitment by all State and Territory governments and the Australian Government. Consultation feedback revealed that while there is significant support for this reform, this was accompanied by some concern that the scale of the task could diminish the likelihood of resolution and lead to wasted resources. For this reason, this Review recommends that harmonisation efforts commence with one specific type of legislation or regulation as a starting point. Commencing with smaller-scale efforts to progress a program of work may further mitigate some of these risks. For example, harmonisation efforts could be commenced by initiating a shared glossary of terminology to break down definitional inconsistency between jurisdictions.

As above, the priority area of legislation and regulation for potential harmonisation efforts is **drugs and poisons** legislation, because it has been observed through this Review to have the most significant material impact on primary care health professional scope of practice. Legislative and regulatory instruments relating to **mental health** and **radiation safety** would represent the proposed next priority areas for review and potential harmonisation to identify and resolve broader definitional issues.

Enable self-regulated professions to operate at full scope of practice through targeted legislative amendments to remove existing barriers

The necessity of additional reforms to ensure the improved recognition of self-regulated professions has been emphasised throughout this Review. Professions who self-regulate may be facilitated by membership with the National Alliance for Self Regulating Health Professions (NASRHP), which supports national consistency in the quality of self-regulated health professions and provides a framework for standards to achieve this objective. Standards for self-regulated professions under NASRHP closely model those expected of NRAS regulated professions. In addition to NRAS regulated and self-regulated professions, there are several health professions who are regulated via non-National Law legislation and local regulatory mechanisms. [105]

As noted throughout this section, there are significant issues linked to the lack of NRAS regulation which prevent self-regulated professions from carrying out activities which are within their education, training and competency. Evidence, including from the review of legislation and regulation undertaken as part of this Review, strongly points to self-regulated professions being precluded from performing activities for which they are competent, and which are within scope, due not only to the widespread practice of shorthand references to the National Law but to broader issues of interprofessional recognition and understanding. [106] This is not consistent with the intent of the National Law, but rather is due to the cumulative impact of many other legislative and regulatory instruments.

[105] Non-registered health professions are an important and growing workforce who deliver care across primary care, disability, aged care and other health settings supported by various regulations and clinical governance arrangements. It is important to note that many peak professional associations for non-registered health professions offer voluntary certification programs, including qualifications, practice and probity standards for members, accreditation of training programs and publication and maintenance of a code of conduct that applies to all members.

[106] While non-registered professions are also not regulated under the NRAS, on balance of evidence, fewer scope of practice barriers emerged for these professions, other than self-regulated professions, in terms of activities clearly within their scope that they were unnecessarily prevented from doing for reason of the regulatory mechanism they sit within.

Currently, a two-step assessment process applies where health professions make submissions to enter the NRAS and become registered.

1. Initially, Ministers consider submissions against six 'threshold criteria' outlined below, of which Criteria 2 has the most relevance for the non-registered status of self-regulated professions.
2. If a profession is deemed eligible against all criteria, a sponsoring jurisdiction must then deliver a Regulatory Impact Assessment (RIA), which assesses risks, costs and benefits of the profession entering the NRAS. The RIA must demonstrate that benefits to the public of regulation clearly outweigh the potential negative impact of such regulation, in order for the profession to be considered eligible for registration.

Criteria for regulatory assessment of the need for statutory registration of a health profession[107]

1. Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?
6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

To date, most self-regulated professions have not been determined to meet the above eligibility criteria at the first step of the assessment process, on the basis of being deemed ineligible against the 'significant risk of harm to the 'health and safety of the public' threshold criteria (Criteria 2 above). By not meeting this criteria, self-regulated professions are not afforded title protection under the National Law. As outlined above, an unintended consequence of the National Law is that pervasive shorthand references to the National Law in other legislation and regulation excludes self-regulated professions because they lack title protection.

The scope of practice implications of this issue were clearly drawn out through this Review. Because the definition of a health professional is linked to the National Law, professionals who are not included in this definition are blocked from carrying out myriad activities governed by a range of legislation and regulation that refer to that definition, in a way which is not consistent with their actual skills and competence. Further, these scope of practice issues carry implications for public access to self-regulated professions, as well as consumer understanding and confidence in relation to these professions' scopes of practice, because there is reduced visibility to the consumer about the activities which these professions are educated and competent to perform.

Consultation Insights

Audiology is a self-regulated profession and a member of NASRHP. Audiologists achieve a Masters' level qualification to provide their primary care role. This may also involve collaboration with ear, nose and throat specialists, GPs and other members of the primary care team.

The audiometry profession is regulated by non-National Law legislation and jurisdiction-based regulatory processes. Audiometrists complete a range of certifications, including to Diploma level, and conduct hearing tests across a range of settings.

Currently, there is the potential for public (and health professional) confusion about the expected role of the two professions. Without registration and title protection, there is no mechanism to address this.

[107] Australian Health Ministers' Advisory Council (2018) AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions. Accessed 11 July 2024.

The ABR approach detailed in above sections is acknowledged to go some way to resolve scope of practice barriers for self-regulated professions in some areas, by limiting unnecessary references to title protection in legislation and regulation which indirectly impacts scope of practice. As outlined above, this would involve amendment of targeted areas of legislation and regulation to amend how the National Law is invoked as a 'shorthand' reference. The targeted review and potential harmonisation of legislation and regulation detailed above is recommended on the basis that it will address, in the first instance, scope of practice areas where self-regulated professions are most materially impacted.

However, to more substantively address scope of practice issues for self-regulated professions, a large volume of State and Territory statutes would need to be individually reviewed and amended to harmonise and remove references to protected titles. This would be a lengthy and resource-intensive process, likely to drive complexity and unlikely to resolve scope of practice issues for self-regulated professions in an efficient manner. For this reason, this Review has concluded that there are additional potential solutions which would comprehensively support self-regulated professions.

These potential options, outlined below, are judged to represent a relatively straightforward path to resolving scope of practice barriers for self-regulated professions, and could be carried out in conjunction with the solutions recommended under Recommendations 6 and 7. Consideration of the below options is essential to better recognise the important role of the self-regulated professions in delivering primary care.

Notwithstanding that the primary focus of this Review is to resolve scope of practice issues, there are potential secondary benefits of proposed options related to the increased regulation of self-regulated professions. These options include incorporating a range of self-regulated health professions under the NRAS, as well as alternative regulatory pathways for self-regulated professions. There are a range of potential broader benefits of these options which extend beyond the core intent of this Review. Self-regulated professions stand to benefit from a greater degree of interprofessional regulatory support, consistency and clarity than they currently receive. Existing barriers to accessing scholarships and educational grants, and inclusion in new workforce policies and workforce data, are further potential benefits. These in themselves may prompt self-regulated professions' scopes of practice to be more clearly understood by the broader multidisciplinary health care team, with further positive implications for scope of practice.

"It is the view of the self-regulating health professions that an additional focus on how the current model of self-regulation may be updated, and what a pathway towards development and implementation of that model looks like, is needed."

Allied Health Professions Australia and the National Alliance of Self Regulating Health Professions

Options to strengthen and standardise regulation of self-regulated professions

A range of potential reforms are available to strengthen and standardise regulation and remove unnecessary barriers to working at full scope of practice for self-regulated professions, all of which carry associated risks and benefits. Determination of a preferred option would be reached through undertaking a Risk Impact Statement (RIS) or Policy Impact Analysis (PIA), which should consider below decision-making criteria.

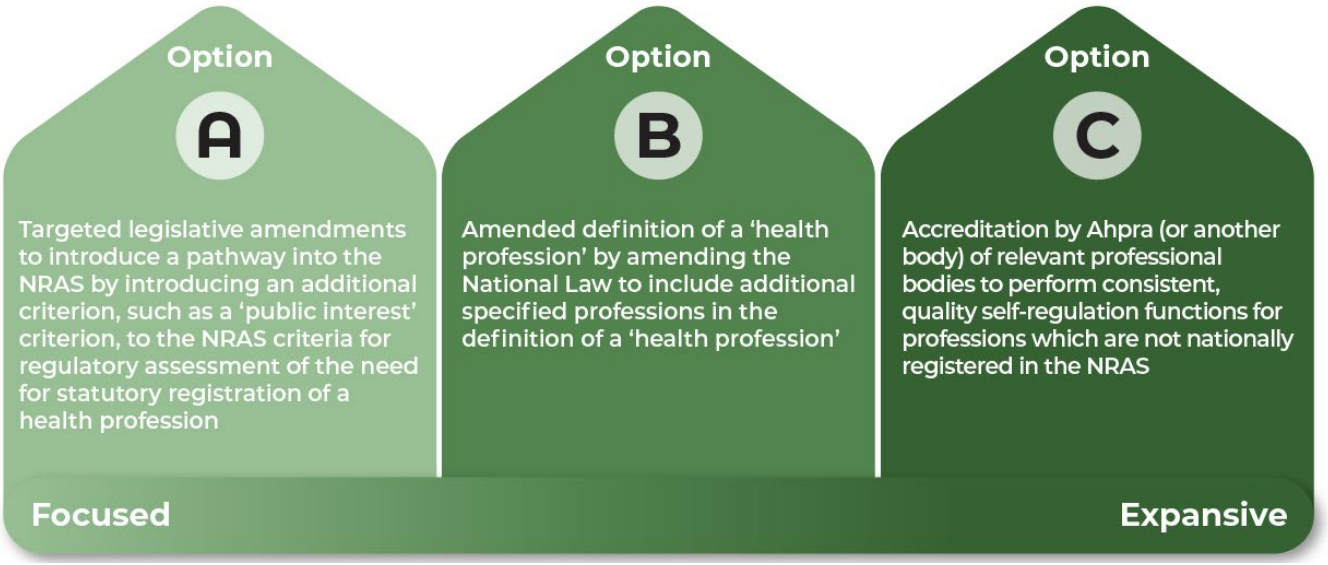
Potential options for reform are presented below, ranging from focused to expansive in nature as summarised in Figure 8. These differ in terms of time and resources required to implement, as well as the direction of ongoing regulatory cost burdens (i.e. towards government, or towards professional organisations).

Decision-making criteria

The below criteria respond to the main policy issues identified through this Review as impacting self-regulated professions, and should be considered as decision-making criteria within the RIS or PIA undertaken to identify a preferred option.

- Extent to which the options **recognise and formalise** the role of self-regulated professions within the system, including in relation to their scope of practice
- Extent to which the options **minimise barriers** embedded in the legislative and regulatory environment to self-regulated professions working to full scope of practice
- Extent to which the options **protect public safety**, through strengthened regulatory mechanisms in relation to self-regulated professions
- Anticipated **time impact** required to implement the options
- Anticipated **cost impact** required to implement the options, and to whom costs would accrue.

Figure 8 Summary of possible mechanisms to support self-regulated professions



Option A

Targeted legislative amendments to introduce a pathway into the NRAS involves amendment of the requirement that a self-regulated profession must pose 'significant risk' to the 'health and safety of the public' in order to be considered eligible to be regulated under the NRAS. To progress this, the HMM would amend their previous decision requiring professions to demonstrate potential for 'significant risk' in order to be eligible, and introduce a new additional criterion. This option would provide a pathway for eligibility for regulation under the NRAS, and to title protection, by self-regulated professions provided they demonstrate they meet newly established criteria. These criteria may take the form of a 'public interest' criterion (per the precedent set by the New Zealand approach to regulating health professions, explained below).

Public interest criteria: Health practitioner regulation in New Zealand

Regulation of health professions in New Zealand follows a two-step assessment process including primary and secondary criteria and completion of a regulatory impact analysis, similar to the Australian process. Like the Australian process, primary criteria include an assessment of the potential for public harm.[108] However, unlike the Australian system, the New Zealand primary criteria also incorporates a 'public interest' statutory criterion whereby a profession can be eligible for regulation without necessarily posing a significant risk of harm to the public. Primary criteria which health professions must meet to fall under consideration for regulation are:[109]

(a) that the profession delivers a health service (as defined in the Act)

(b) either (i) the health services pose a risk of harm to the public or (ii) **it is otherwise in the public interest** that the provision of health services be regulated as a profession under the Act

(c) that providers of the health services concerned are generally agreed on the required qualifications, relevant standards for practice and the competencies for scopes of practice for the health services.

Upon being considered to meet the above criteria, a RIA must be completed which demonstrates professional registration would carry benefits to the public which clearly outweigh the negative impacts, that regulation is both possible and practical to implement, and that existing regulatory or other mechanisms fail to address health and safety issues. The Ministry of Health must be satisfied of the above secondary criteria being met in order for the profession to become regulated under the Act.

Eligibility for statutory regulation in the public interest includes professional groups that:

- Practise without the supervision or support of peers, managers, and other regulated health practitioners
- Are highly mobile, locum, or work on short tenure
- Are not guided by a strong professional (or employer) code of conduct
- Provide services to vulnerable or isolated individuals
- Are subject to such large numbers of complaints about the quality of services that oversight of competence from an independent body is required
- Carry out roles where the training and educational requirements are short and there is no extended period through which the ethos and values which underpin safe practice can be absorbed.

[108] New Zealand Government Manatu Hauora Ministry of Health (2023) Regulating a new profession. Accessed 11 July 2024.
[109] New Zealand Parliamentary Counsel Office. (2023) Health Practitioners Competence Assurance Act 2003, Section 116 (a). Accessed 11 July 2024.

The RIA process would be a continuing core component of this mechanism, as it is in the current assessment process for entry into the NRAS. The current RIA process theoretically takes scope of practice benefits into consideration; however, the overarching 'threshold criteria' for entry to the NRAS stipulate that professions which do not meet the 'significant risk of harm' criteria remain ineligible regardless of whether there are demonstrable scope of practice benefits to registration. The current regulatory pathway is therefore limited in its capacity to resolve scope of practice challenges faced by self-regulated professions.

With the addition of the proposed new eligibility criteria, a sponsoring jurisdiction would be required to complete a RIA as per the current process. This would need to demonstrate that the profession pursuing a pathway into the NRAS meets the new 'public interest' criteria and/or the existing 'risk to public health and safety' criteria. This means that in assessing the case for health professionals entering into the scheme, the new public interest test would co-exist as an additional consideration; if the RIA were to demonstrate that it was in the public interest of a profession to be regulated, they could be considered eligible whether or not they also were demonstrated to pose a public safety risk.

Possible eligibility criteria suitable for a 'public interest' test for health professional registration could include the following examples:

- Registration would facilitate improved access to services provided by health practitioners working to full scope of practice, particularly for underserviced areas and disadvantaged groups
- Registration would enable the more flexible, responsive and sustainable use of the Australian health workforce
- The profession provides care to complex, vulnerable or isolated individuals
- The profession practises without the supervision or support of peers, managers, and other regulated health practitioners
- The community would benefit from being able to identify appropriately trained and qualified individuals.

The RIA process would need to demonstrate that the benefits of registration would outweigh the disbenefits in order for registration to be considered appropriate for that profession. This, in effect, would take a broader view of the potential benefits and disbenefits of registration, not limited to consideration of public safety impacts alone, while continuing to ensure any registration of any additional health professions is appropriate and proportionate. The indicative list of self-regulated professions to whom this option would initially apply is given in Option C, noting the final decision would be reached via the RIA process to determine a preferred option.

The mechanism for this reform to be progressed is via the HMM, who would amend the Intergovernmental Agreement [110] for a National Registration and Accreditation Scheme for the health professions. Also required would be a targeted legislative amendment (to the definition of 'COAG Agreement' in the National Law), without which the amendment to the Intergovernmental Agreement would have no legal effect. Professional associations wishing to make a submission for inclusion of their profession in the NRAS would be required to engage with the relevant jurisdiction to seek support for their proposal, prior to submission to the HMM and decision on whether to progress to a RIA. [111]

This option provides national registration and title protection for self-regulated professions. Regulatory mechanisms that support the reforms would be administered under the governance of Ahpra and would require the establishment of new National Board(s). This could be undertaken through either:

A. The establishment of new separate National Boards for the additional professions, or
B. A Multidisciplinary National Board responsible for a group of regulated professions.

There are potential benefits of the Multidisciplinary National Board option in terms of encouraging multidisciplinary, rather than profession-specific regulatory models. The former model may potentially be implemented more efficiently than the latter. This is in keeping with evidence suggesting a growing trend toward multidisciplinary regulation and umbrella legislation internationally. [112] However, the governance of such a joint board will need to be carefully managed to ensure it serves the interests of all health professionals within its remit.

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[110] Referred to as the Council of Australian Governments (COAG) Agreement within the legislation.

[111] Australian Health Ministers' Advisory Council (2018) AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions. Accessed 11 July 2024.

[112] Carlton A, Leslie K, Bourgeault IL, Balasubramanian M, Mirshahi R, Short SD, et al. (2024) Health Practitioner Regulation Systems. A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems. Canadian Health Workforce Network. Section 116 (a). Accessed 11 July 2024.

Option B

Amended definition of a 'health profession' requires legislative amendments to the National Law, to include additional specified professions in the definition of a 'health profession'. That is, where 'health professions' currently included within this definition are limited to the 16 professions regulated under the NRAS, additional specified professions could be added by amending Section 5 of the National Law. This approach would automatically enable legislation and regulation which refers to the National Law definition of 'health professional' to also apply to selected additional professions (as and when the legislated activity falls within their scope of practice). Additional professions to whom the definition would be extended would be defined as meeting criteria, such as that they play a significant role in delivering primary care and where greater regulation would afford additional confidence in the safety of the health care system. An indicative list of potential professions to whom this option may apply is provided under Option C below, noting the range of professions would ultimately be determined by a RIA process.

This option could be progressed in a relatively targeted manner and is likely relatively less resource-intensive to implement than Option A, which bring self-regulated professions under the NRAS. This option does not grant self-regulated professions full status as registered professions under the NRAS, nor the full benefits of title protection. One possible pathway for legislative drafters in progressing Option B would be the introduction of a second definitional category of health professions defined within the National Law.

While this option is likely to partially resolve issues facing self-regulated professions linked to the pervasive use of shorthand references to the National Law in legislation and regulation, there are limitations to consider in its capacity to produce the intended outcome of reduced exclusion of self-regulated professions from legislation and regulation. This is due firstly to the level of inconsistency in the way legislation and regulation make reference to the National Law. As an example, Table 3 shows a sample of legislation within one jurisdiction (Queensland) indicating the range of definitions which make reference to the National Law. Importantly, all definitions in this sample refer to 'registered professions'. Because Option B would not lead to registration of self-regulated professions, self-regulated professions would continue to be excluded from these examples of legislation, and from others which refer similarly to the National Law definition. For these reasons, this option is relatively less likely to straightforwardly or substantively resolve the core issue of shorthand references limiting the scope of practice of self-regulated professions.

Table 3 Sample of Queensland legislation referring to the National Law

Legislation	Definition
Medicines and Poisons Act 2019 (QLD)	**health practitioner** means— (a) a health practitioner registered under the Health Practitioner Regulation National Law; or (b) another practitioner who provides a service for maintaining, improving, restoring or managing people's health or wellbeing; or (c) an individual training to be a practitioner mentioned in paragraph (a) or (b).
Radiation Safety Act 1999 (QLD)	**health practitioner** means— (a) a person registered under the Health Practitioner Regulation National Law; or (b) a person practising in a health-related field who is accredited by a professional body representing practitioners in the field.
Termination of Pregnancy Act 2018 (QLD)	**registered health practitioner** means a person registered under the Health Practitioner Regulation National Law to practise a health profession, other than as a student.
Ambulance Service Act 1991 (QLD)	**health professional** means a person registered under the Health Practitioner Regulation National Law to practise, other than as a student, in any of the following— (a) the medical profession; (b) the medical radiation practice profession; (c) the midwifery profession; (d) the nursing profession; (e) the occupational therapy profession; (f) the paramedicine profession; (g) the pharmacy profession; (h) the physiotherapy profession; (i) the psychology profession.

Option C

Accreditation of relevant professional bodies to perform consistent, quality self-regulation functions for professions which are not registered in the NRAS would introduce a strengthened, national approach to regulation other than full statutory registration under the NRAS. Under this option, Ahpra (or another body) would be granted a new role of external accreditation of a range of self-regulation functions, performed by a body external to Ahpra and responsible for the ongoing regulation of select self-regulated professions. To ensure the intent of this regulatory change carries through to address the core issue for scope of practice, i.e. shorthand references to the National Law in legislation and regulation, the National Law should be amended to add a reference to this group of self-regulated professions.

The self-regulation functions of entities accredited by Ahpra may include, for example, a voluntary register of self-regulated professions, based on the model of regulation used in the UK through their Professional Standards Authority Accredited Registers Program (see explanation below). The concept of establishing a system of quality assurance for voluntary registration of self-regulated professions has been previously put forward to government across a number of reviews and consultation papers, initially raised in the 2014 Independent Review of the National Registration and Accreditation Scheme for Health Professionals [113] but was not progressed in favour of administrative efforts to better communicate the intended role of the NRAS. The findings of the current Review around the unintended scope of practice consequences for non-registered professions arising from their exclusion from the NRAS is cause to reconsider this option. These adverse impacts are also noted in the *Review of complexity in the National Registration and Accreditation Scheme Consultation Paper 1.* [114]

The UK Professional Standards Authority Accredited Registers Program

The UK Accredited Registers Program gives the Professional Standards Authority a voluntary accreditation role of professional associations' public registers, for which they have published minimum standards. Under the program, any professional association which operates a public register of qualified members can choose to apply to the Professional Standards Authority to undertake third-party accreditation of that register.

The UK currently has 28 health professional registers accredited in this way. Only health professionals who appear on accredited registers can advertise to the public as such, and the public are encouraged to choose PSA accredited health professionals.

The PSA holds statutory power to remove professional associations' accreditation, suspend the accreditation of a voluntary registrant, or apply other conditions. This approach was deemed a proportionate way of balancing improved public assurance that health professions are meeting standards against the regulatory complexity and cost associated with health professional regulation.

If the above model were progressed, this option would incorporate a new external accreditation and certification role under Ahpra for a national self-regulating entity, who would maintain control of a voluntary register of health professions. This national self-regulating entity may be an existing entity, such as NASRHP, or alternatively consist of an amalgamation of existing professional bodies or a newly established professional body. Ahpra would apply minimum standards to the register of health professionals maintained by that self-regulating entity.

[113] Snowball K. (2014) Independent Review of the National Registration and Accreditation Scheme for Health Professionals Final Report.
[114] Australian Government Department of Health and Aged Care (2024) Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Accessed 20 September 2024.

The National Law would need to be amended to recognise practitioners on these registers as such, without which the status of these practitioners would go unrecognised across the wide range of legislation and regulation which make shorthand reference to the National Law. The National Law would also require recognition of the accreditation functions to be undertaken by national self-regulating entities, as well as the new certification role to be performed by Ahpra. The indicative list of self-regulated professions to whom this option would initially apply is given below, assumed to apply to all of Options A, B and C, noting the final decision would be reached via the RIA process to determine a preferred option.

Indicative priority self-regulated professions

The below self-regulated professions are proposed as a starting point for Options A, B and C (subject to final decision through the RIA process):

- Dietitians
- Sonographers (cardiac and medical)
- Audiologists
- Exercise physiologists
- Speech pathologists
- Social workers
- Counsellors.

In performing the role of external accreditation, Ahpra would increase assurance as to the regulatory processes which apply to self-regulated professions by the relevant professional body. This could have benefits for interprofessional trust and understanding of self-regulated health professions' scope of practice. Effectively, this model introduces a 'third tier' of regulation, in addition to NRAS registration and the system of negative licensing that applies to other unregistered professions (as described further below). This option is intended to balance the need for assurance over the scope of practice of health professions with a proportionate response in terms of time and resourcing, as set out in the *Review of complexity in the National Registration and Accreditation Scheme Consultation Paper 1*.[115]

Other non-registered workforces

Non-registered professions who are not self-regulated, including the assistant, support and technician workforces, are currently regulated under a system of negative licensing and a *National Code of Conduct for Non-Registered Health Practitioners*. Consistent with the initial analysis of the *Review of complexity in the National Registration and Accreditation Scheme Consultation Paper 1*,[116] this system is considered by this Review to be an important continuing feature of the primary care regulatory landscape. However, there are opportunities to strengthen its operation to enable stronger and more consistent understanding of all non-registered professions' scope of practice (including but not limited to those who are currently self-regulated).

The Code of Conduct is legislated and funded separately by each State and Territory, of which six of the eight currently have their Code in operation. Powers of jurisdictions to make prohibition orders, or to publish reasons for decision, are not wholly consistent between States and Territories. On this basis, the *Review of complexity in the National Registration and Accreditation Scheme Consultation Paper 1* expressed initial findings that the current negative licensing scheme is not yet fully implemented nationally nor working to its optimal potential.[117] Efforts to improve both functioning and understanding of the negative licensing regulatory scheme are essential to underpin the continued role of unregistered health professions, with potential flow through to support their full scope of practice work.

Process for determining a preferred option

A specific process will apply to the consideration of outcomes related to the proposed options for self-regulated professions. Regardless of which options (A-C) are under consideration, an Impact Analysis would be required (either or both of a PIA or RIA). An Impact Analysis addresses seven questions relating to regulatory change (problem definition, objectives, options, impacts, consultation, conclusion and implementation and review), reviewed by the Office of Impact Analysis within the Department of the Prime Minister and Cabinet.

[115] Australian Government Department of Health and Aged Care (2024) Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Accessed 20 September 2024.
[116] Ibid.
[117] Ibid.

The purposes of undertaking an Impact Analysis as the initial step of determining an appropriate option to pursue, is to make an assessment of the relative advantages and disadvantages of options under consideration, including consideration of cost-efficiency.

Reforms will need to sit within the broader context of reviews, inquiries and reforms currently in progress for health, disability and aged care systems. For example, the recommendations from the NDIS Review includes additional regulatory measures for care providers working within the NDIS.[118] The risk-proportionate model for regulation recommended by the NDIS Review would require advanced registration that includes more intensive obligations regarding conduct and audit processes for all high-risk supports. A graduated regulatory approach would follow through general registration, basic registration and enrolment. Many primary care providers who are members of self-regulated professions provide care within the NDIS.

As the primary care workforce moves across settings and sectors, it will be important to ensure that regulatory measures proposed in this Review integrate effectively with those implemented by the NDIS. The options for self-regulated professions described above offer the potential to introduce greater control and consistency in how relevant health professions are regulated, with potential implications for flexibility and mobility of workforce, if additional self-regulated professions come under NRAS regulation. There are further potential benefits for consumer safety and clarity of health professional scope of practice across sectors. Proposed reforms must also align with health and aged care reforms in the interests of ensuring that the workforce is not subject to misaligned or overly burdensome regulatory requirements.

There are significant consumer access benefits flowing from the combined legislative and regulatory reforms. This is because, instead of needing to go to a specific health profession to receive a particular activity, consumers may have the option to access these services through additional members of their multidisciplinary care team.

Continuity of care will likely improve due to the reduction in unnecessary barriers to health professionals carrying out activities within their scope of practice. In rural and remote areas and regions with workforce shortages, this may be the difference between being able to access timely primary care and facing significant delays or not accessing needed care at all. Consumers who engage with self-regulated professions also stand to benefit particularly from an access to service standpoint, as self-regulated professions gain a stronger authorising environment around what activities within their scope of practice they are authorised to perform.

Intended outcomes

The intent of the combined legislative and regulatory changes outlined above is to:

- Improve and clarify the authorising environment which enables health professionals to carry out activities already within their scope of practice, by removing unnecessary legislative and regulatory barriers relating to references to protected titles and by commencing work with modernising and harmonising legislation and regulation which has the most significant material impact on scope of practice
- Improve the flexibility and responsiveness of legislation and regulation governing emerging models of care, health professions, and best practice through commitment to a more balanced approach to regulating scope of practice which reduces reliance on highly specific and rigid regulatory approaches which focus on protected titles
- Improve definitional consistency and clarity of priority legislation and regulation subjects across jurisdictions, primarily between States and Territories, thereby improving consistency in how scope of practice is governed across jurisdictions
- Better support self-regulated professions to work to their full scope of practice by removing barriers embedded in the way they are currently reflected in legislation and regulation.

The combined reform responds to a significant and highly impactful collection of barriers health professionals observe in attempting to work to their full scope of practice. By commencing efforts with the legislative and regulatory issues observed to most materially impact scope of practice, this body of reform is intended to address and dissolve the most impactful of these barriers. It is more broadly intended as the starting point for a broader commitment to a more balanced, more flexible approach to legislation and regulations.

[118] Australian Government Department of the Prime Minister and Cabinet (2023) Working together to deliver the NDIS – Independent Review into the National Disability Insurance Scheme: Final Report. Accessed 18 July 2024.

"From a community perspective, if we were to harmonise, it would be the first step to look at other issues, e.g., termination of pregnancies [legislation], and looking at how we could have a national consensus on this. This would have a significant impact on patient [accessing care that is] timely, and appropriate."

Consultation participant

Consultation highlighted the importance of both regulated and self-regulated primary care workforces being able to embrace and benefit from reforms that enable health professionals to work to full scope of practice. Restructuring the current approach to health profession regulation, using the proposed reform options, would enable a greater proportion of the primary care workforce to operate to full scope.

"The proposed [in Issues Paper 2] early career primary care competencies reform has significant flaws. The Commonwealth must carefully consider its practical implementation. Notably, two-thirds of the health workforce falls outside the jurisdiction of the Health Practitioner Regulation National Law (HPRNL). Therefore, there is limited authority to enforce these changes unless the Act is amended to recognise self-regulating health professions."

National Alliance of Self Regulating Health Professionals

Regardless of whether title protection for self-regulated professions is progressed (i.e. through Option A), reform options will help to ensure public confidence in the scope of practice of self-regulated professions by introducing greater transparency and certainty through the chosen mechanism. Moreover, interprofessional trust can be strengthened, as professions have improved visibility and assurance about the education, training and competency of their self-regulated colleagues. Combined, these will help to ensure self-regulated professions continue to deliver safe, essential care which better meets the needs of the community.

Impact on multidisciplinary care teams

Existing legislative or regulatory barriers impact multidisciplinary teams from working together as effectively as they could. Multidisciplinary care teams will therefore benefit from greater legislative and regulatory clarity and a strengthened authorising environment enabling each team member to work to their full scope of practice. All members of the care team are expected to benefit from improved understanding of their respective roles and scopes of practice, including where these overlap. Increased professional satisfaction is likely to result from a greater degree of clarity, and overall system responsiveness to best practice evidence.

Greater flexibility of the legislative and regulatory environment more broadly will improve the adaptability and adoption of emerging models of care, particularly those which are multidisciplinary in nature and/or comprise emerging roles or share scope of practice across roles in an innovative way. Addressing the rigidity of the legislative and regulatory environment will also better reflect the context-dependent clinical governance arrangements within multidisciplinary care teams, which influence the extent to which a given activity is safe within a particular team environment. This places the emphasis on interprofessional trust between team members and may strengthen team functioning.

A greater level of consistency between State and Territory jurisdictions will benefit the ability of multidisciplinary care teams to perform to the same scope of practice consistently across borders, with particular potential benefits for border communities and care teams working with transient communities.

"A risk-based approach to regulation aligns well with the principles of rural generalism, in which health professionals retain and further develop a skills set that is shaped by the needs of their community… Better understanding of shared skills sets across professions, underpinned by a national skills and capability framework and driven through Ahpra and the national registration boards, could serve to improve understanding and respect between health professionals necessary when working as part of a multidisciplinary team."

Services for Australian Rural and Remote Allied Health

Primary care teams would benefit from greater clarity around the role and unique contribution of members of the self-regulated professions, and the removal of unnecessary legislative and regulatory barriers to their contributions to primary care. This should have a positive impact on trust and cohesiveness within the team and may support inclusion of a greater breadth of professions because of an improved understanding and transparency of scope of practice.

"A risk-based approach to regulation will encourage health professionals to work in partnership rather than persist in a siloed approach... A collaborative, respectful approach to care will improve health outcomes and provide the patient with a better experience along the health care journey."

Australian College of Nursing

All stakeholders who engage with the primary care system further stand to benefit from improved system responsiveness, and a future-proofed health system which is able to keep pace with (and contribute to) international best practice.

In relation to proposed options for self-regulated professions in particular, the proposed reforms will benefit a range of stakeholders, including:

- Consumers and First Nations peoples would benefit from greater clarity in the role of self-regulated professions. This will enable them to make informed choices regarding their health care.
- Health professionals, primary care multidisciplinary teams would benefit from an improved understanding of the role of members of the self-regulated professions, provided by the educational reforms proposed in *Section* A2.
- Employers and health services would benefit from greater certainty regarding health professional roles and processes that support safe and ethical practice.
- Education providers and accreditation authorities would benefit from enforceable practice standards that provide a clear mandate on which to base the design, development and assessment of curricula, if Option A or C is progressed.
- Professional organisations would benefit from accreditation by a regulatory body through which contemporary practice expectations and regulatory functions can be assured.
- Professional indemnity insurers would benefit from clarity regarding expected practice and scope.

Enablers

Culture change management will be required to accompany a reform effort of this scale. Each of the implementation options detailed in this reform option will require significant engagement in order to reach consensus between all decision-makers. State, Territory and Australian governments will need to commit to an aligned reform agenda. In relation to the options for self-regulated professions, extensive consultation will be required to communicate the reform options to relevant stakeholders, and determine the most appropriate reform path that effectively balances public safety and improved regulation.

Likewise, effective change management processes would support a **change in culture in relation to (currently) self-regulated professions**, which will be necessary to support all stakeholders to understand and embrace the new regulatory processes. These change management processes should include: inclusive and transparent leadership; effective, regular and inclusive communication with all stakeholders; education to support all stakeholders; and feedback and ongoing monitoring mechanisms. Targeted education programs will be required to support consumer, First Nations and community understanding of the regulatory change.

There is also need for attention at a service level to enable the intent of legislation and reforms to flow into practice. The role of the multidisciplinary care team must be reinforced in parallel to ensure siloed practice is not reinforced. As stated above, there is an interdependency with the strength of team **clinical governance arrangements** to support continuing safe scope of practice.

"A strategy based on risk or activity, supported by a uniform method to documenting individual professional scopes of practice, could greatly facilitate more adaptable service provision from a wider range of professions, while maintaining safety. However, documenting scope, regardless of approach, will only support reforms if other enabling changes across legislation and funding guidelines are made."

Australian Physiotherapy Association

Recommendations

Recommendation 6: Health Ministers agree to progress activity-based regulation of scope of practice to complement the status quo protection of title approach. This would apply in instances where a clinical activity that is to be regulated through Australian, State or Territory legislation, excluding the National Law or National Registration and Accreditation Scheme (NRAS):

- Is effectively common or shared across a number of health professions, or has the potential to be, or
- Is a novel clinical activity not currently performed or undertaken only by a single discipline, and
- Meets an appropriate risk threshold, and
- Is in the public interest consistent with the objectives of the National Law, S3 (2) [a-f].

6.1 Health Ministers agree to prospectively:

- Limit in future legislation and regulation the use of protected titles as the primary means of regulating and restricting activities in legislation unrelated to the National Law or the direct regulation of health professionals, i.e. shorthand references - and instead
- Adopt an approach based on assessment and management of the inherent risk associated with the activity being regulated or restricted.

6.2 The Health Ministers' Meeting (HMM) request National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) to commence identification of activities falling within an overlapping scope across professions, to inform relevant programs of review and potential harmonisation of existing legislation and regulation (see Recommendation 7), guidelines and standards, and/or education programs.

Recommendation 7: Health Ministers agree to a program of review and potential harmonisation of existing legislation and regulation which:

- Contain unnecessarily restrictive application of *shorthand references*, and
- If replaced by an activity focused approach (see Recommendation 6), would enable a wider range of health professionals to undertake the restricted activity consistent with their scope and in the public interest.

7.1 Commence the program review and potential harmonisation of existing legislation and regulation with the following:

- Drugs and Poisons Acts
- Radiation Safety Act
- Mental Health Acts.

Recommendation 8: The Health Ministers' Meeting (HMM) agree to strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation Scheme (NRAS) to:

- Enable the community to access and benefit from all health professionals working to their full scope of practice in multidisciplinary teams in primary care.
- Ensure safety and quality of care delivered by the self-regulated health professions.

8.1 HMM agree to commission a rapid impact analysis of the three reform options to determine which option/s meet the criteria defined above and are cost-effective:

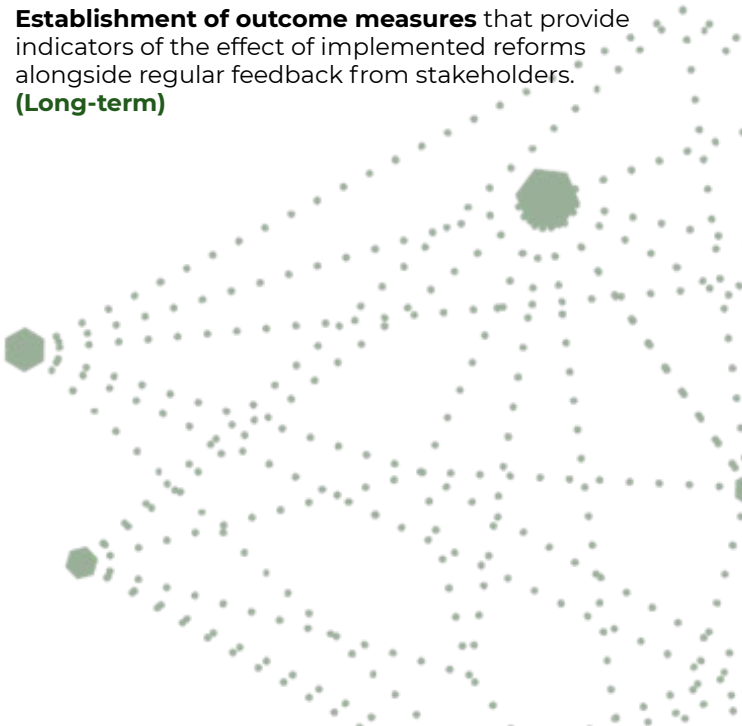
- **Option A** – targeted legislative amendments to introduce a pathway into the NRAS by introducing an additional criterion, such as a 'public interest' criterion, to the NRAS criteria for regulatory assessment of the need for statutory registration of a health profession
- **Option B** – amended definition of a 'health profession' by amending the National Law to include additional specified professions in the definition of a 'health profession'
- **Option C** – accreditation by the Australia Health Practitioner Regulation Agency (Ahpra) (or another body) of relevant professional bodies to perform consistent, quality self-regulation functions for professions which are not nationally registered in the NRAS.

Implementation

- **HMM adopts principle of ABR and agree to a program of implementation**. Health Ministers agree to the principle of activity-based regulation to complement protection of title approach, to be applied retrospectively and prospectively. **(Short-term)**
- HMM request National Boards and Ahpra to commence identification of activities falling within an overlapping scope across professions. This may align with activities in the establishment of the National Skills and Capability Framework and Matrix. **(Short-term)**
- **HMM initiates review of existing legislation and regulation.** Health Ministers agree to a program of review of existing legislation and regulation which contain unnecessarily restrictive application of shorthand references, and which if replaced by an activity-based approach would enable a wider range of health professionals to undertake the restricted activity consistent with their scope and in the public interest. Ministers agree to commence with Drugs & Poisons Acts, Radiation Safety Acts and Mental Health Acts. **(Short-term)**
- **HMM initiates harmonisation of existing legislation and regulation.** Health Ministers agree to a program of harmonisation of existing legislation and regulation requiring greater consistency between State and Territory, and which meet the above criteria. Ministers agree to commence with Drugs & Poisons Acts, Radiation Safety Acts and Mental Health Acts. **(Short-term)**
- **Identification of activities falling within an overlapping scope across professions.** HMM requests National Boards and Ahpra agree the principles and a shortlist of activities which will be subject of proposed activity-based reform, which meet an appropriate risk threshold and/or are novel clinical activities performed or undertaken by multiple disciplines and are in the public interest consistent with objectives of the National Law, S3 (2) [a-f]. This may refer to the Skills and Capability Framework and Matrix. **(Medium-term)**
- **Harmonisation of legislation and regulation.** Based on the above, governments agree to pursue harmonisation (including reviewing and replacing as appropriate references to the National Law) to the extent possible in line with the intent of HMM policy direction, commencing with Drugs & Poisons Acts, Radiation Safety Acts and Mental Health Acts. Governments work together to reach agreement on priority areas for commencement of harmonisation, such as a shared glossary. **(Medium-term)**
- **Identification and amendments to legislation that limits scope of practice.** Australian, State and Territory governments work to identify broader legislation which limits scope within their jurisdictions (may include legislation which is not directly concerned with regulation of health professionals). **(Long-term)**
- **Guidance provided to legislators and regulators.** Promotion of HMM guidance to advise ongoing approaches to developing legislation and regulation with a balanced activity-based and protection of title-based approach. **(Ongoing)**

Implementation of the reforms related to self-regulated professions will require a tailored approach, depending on which reform option/s are chosen. An indicative implementation approach would include:

- **Extensive engagement with all stakeholders** to describe the possible reform option/s. This would involve all self-regulated professions, consumers including First Nations consumers, government, professional associations, education providers, insurers and Ahpra representatives. **(Short-term)**
- **Undertaking a Regulatory Impact Analysis and/or Policy Impact Analysis** to determine the reform option that best enables professions to meet the defined criteria described in Recommendation 8, considering the public interest, cost, proposed timeframes and regulatory impact. **(Short-term to medium-term)**
- **Ongoing and inclusive engagement** with stakeholders during the reform process. **(Medium-term)**
- **Implementation of change management processes** that support transition to new regulatory processes once confirmed. Include extensive education for all stakeholders. **(Medium-term to long-term)**
- **Establishment of outcome measures** that provide indicators of the effect of implemented reforms alongside regular feedback from stakeholders. **(Long-term)**



B2. Independent, evidence-based support for health workforce innovation, access and productivity

Summary

Australian primary care is delivered by a large and diverse workforce. Optimal service delivery requires workforce development and planning informed by a comprehensive, data-driven, evidence-based understanding of the services required, including emerging needs, and the available workforce to provide care. These data and underpinning evidence are also important foundations of service innovation.

The NHRA [119] includes goals to drive best-practice and performance using data and research and to 'improve efficiency and ensure financial sustainability'. These goals are relevant to all health sectors, especially given the complexity of the broader health system and the need for consumers to access care across a range of health care settings.

Understanding community needs, existing services and the primary care workforce

A range of data sources contribute to our understanding of the *needs of the community* and *services* provided by the primary care sector, including:

- Department of Health and Aged Care (DOHAC) MBS claims data, Pharmaceutical Benefits Scheme (PBS) and Practice Incentives Payment data
- Australian Bureau of Statistics census, health survey and patient experience survey
- Australian Institute of Health and Welfare health and welfare expenditure database, Australia's Health. [120]

The diverse spectrum of primary care providers makes establishing a comprehensive view of the entire workforce challenging. A range of tools describe the health workforce, including the DOHAC workforce data tool, [121] the national health workforce dataset [122] and the Jobs and Skills Atlas produced by Jobs and Skills Australia. [123] However, available data is frequently linked to information that describes the regulated health professional workforce, rather than identifying the broader workforce. Additionally, the data is infrequently specific to primary care.

There is a need to establish mechanisms that identify data reflective of the broad primary care workforce, inclusive of self-regulated and other primary care health professionals, to inform workforce planning and design. In the absence of appropriate data, there is the risk of undermining workforce planning and broader policy.

Identifying and understanding evidence to support primary care

Healthcare is shaped by evidence obtained from a range of sources. New research, local innovation and emerging technology continually improves the way health care is delivered. However, health professionals raise many examples of the negative impacts of a highly prescriptive and inflexible legislative and regulatory environment, or program restrictions and payment rules, on the timely adoption of better practice and innovative workforce models of care. Specifically, stakeholders identified circumstances where legislation and regulation, and program payment rules, acted as a barrier to evidence-based, patient-centred care. For example, the inability to scale up community paramedic models, despite the model of care proving successful in pilot programs, because existing legislation and employment conditions dictate specific aspects of paramedic practice. In addition, identifying, understanding and applying evidence to practice can be challenging, especially given the complexity and fragmented nature of the primary care system, and the breadth of care options available within it.

[119] Australian Government Department of Health and Aged Care (2024) 2020-25 National Health Reform Agreement (NHRA). Accessed 17 July 2024.
[120] Australian Institute of Health and Welfare (2024) Australia's health. Accessed 31 July 2024.
[121] Australian Government Department of Health (2022) Health Workforce Data. Accessed 17 July 2024.
[122] Australian Government Department of Health (2022) National Health Workforce Dataset. Accessed 17 July 2024.
[123] Australian Government Jobs and Skills Australia (n.d.) Jobs and Skills Atlas. Accessed 17 July 2024.

The role of community pharmacists in providing vaccinations

Community pharmacists have a critical role in providing a range of primary care services. As medicines experts, pharmacists are recognised for their role in supporting the community to access, understand and use their medicines safely and effectively.

Community pharmacists provide accessible health care. Community pharmacies are the most frequently accessed and most accessible health destination, as evidenced by the following: [124]

- Every person visits a community pharmacy, on average, 18 times per year (in metropolitan, rural and remote locations)
- There are more than 443.6 million individual patient visits each year to a community pharmacy
- Australia has more than 2,000 pharmacies that are open after hours, including on weekends
- 96% of people living in capital cities have access to at least one pharmacy within a 2.5 km radius, while in other areas, 74% of people are within 2.5 km of a pharmacy
- In rural and remote areas (MMM 3-7), there are approximately 566 towns that have only one pharmacy and in many cases, the pharmacist is the only health professional in that town. [125]

During the COVID-19 pandemic, pharmacists continued to provide accessible health care and supported the community by playing an instrumental role, in conjunction with other health professionals, in the administration of vaccinations according to national immunisation guidelines.

Competence

Many community pharmacists are authorised to administer vaccinations. Authorisation requires pharmacists to successfully complete an approved vaccination training program which aligns to the National Immunisation Education Framework for Health Professionals. [126] Standards are available to support the accreditation of training programs that enable pharmacists to administer vaccines. [127]

Funding

Pharmacists who participate in the National Immunisation Program Vaccinations in Pharmacy (NIPVIP) Program [128] receive a payment from the Australian Government to administer vaccines that are included in the National Immunisation Program Schedule. [129] This program enables consumer access to affordable vaccinations provided in community pharmacies, residential aged care and disability homes. A range of other vaccinations that fall outside the NIPVIP are also available for access through community pharmacist vaccination programs via a combination of user pay and jurisdictional funding arrangements. However, these are not consistent across the country.

Regulation

Professional practice expectations and guidelines are available to support pharmacists who administer vaccinations, including:

- The Pharmaceutical Society of Australia (PSA) professional practice standards (Standard 11. Administration of a medicine) [130] and practice guidelines for the provision of immunisation services. [131]
- The Australian Immunisation Handbook [132] which provides evidence-based clinical guidelines to support all health professionals who administer vaccinations.
- Guidelines produced by the Australian Technical Advisory Group on Immunisation (ATAGI). [133]

A range of additional criteria detailed in the NIPVIP govern the practice of pharmacists who provide vaccinations, including the need for patient consent, pharmacy registration with the Australian Immunisation

[124] Pharmacy Guild of Australia (2024) Fact sheets. Accessed 1 October 2024.
[125] Pharmacy Guild of Australia (2024) Rural and Indigenous Health. Accessed 1 October 2024.
[126] Australian Government Department of Health and Aged Care (2017) National Immunisation Education Framework for Health Professionals. Accessed 1 October 2024.
[127] Australian Pharmacy Council (2020) Standards for the Accreditation of Programs to support Pharmacist Administration of Vaccines. Accessed 1 October 2024.
[128] Pharmacy Programs Administrator (2022) National Immunisation Program Vaccinations in Pharmacy (NIPVIP) Program. Accessed 1 October 2024.
[129] Australian Government Department of Health and Aged Care (2024) National Immunisation Program Schedule. Accessed 1 October 2024.
[130] Pharmaceutical Society of Australia (2023) Professional Practice Standards 2023 (Version 6). Accessed 16 September 2024.
[131] Pharmaceutical Society of Australia (2020) Practice Guidelines for the provision of immunisation services. Accessed 16 September 2024.
[132] Australian Government Department of Health and Aged Care (2024) Australian Immunisation Handbook. Accessed 16 September 2024.
[133] Australian Government Department of Health and Aged Care (2024) Australian Technical Advisory Group on Immunisation (ATAGI). Accessed 16 September 2024.

Register (AIR), vaccine storage requirements and service provision expectations. In addition, patient eligibility criteria for vaccination are defined.

Legislation

State and Territory legislation determines the vaccines that can be administered in pharmacies, residential aged care facilities and disability homes. Despite national practice expectations, accreditation standards for education programs and governance mechanisms and a national funding arrangement for the NIPVIP, a range of inconsistencies are observed in pharmacist vaccination across the country and reflected in relevant State and Territory legislation. As a consequence, consumers may be eligible to receive a subsidised vaccine in one jurisdiction but the same vaccine will not be subsidised in another.

To illustrate these inconsistencies, Table 4 provides a summary of the vaccines available for pharmacist administration across different jurisdictions.

Table 4 Comparison of a selection of common vaccinations available in community pharmacies across States and Territories[134]

Vaccine preventable disease	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Haemophilus influenzae type b	5 years and over	5 years and over	5 years and over[a]	2 years and over	5 years and over	Not permitted	Not permitted	Not permitted
Herpes zoster	50 years and over (specified brand)	18 years and over (specified brand)	5 years and over[a]	2 years and over	5 years and over	18 years and over (specified brand)	50 years and over[b,c]	5 years and over
Influenza	5 years and over	5 years and over	5 years and over	No restrictions	5 years and over	5 years and over[d]	5 years and over[c]	5 years and over
MPox	Not permitted	Not permitted	18 years and over	Not permitted	Not permitted	Not permitted	5 years and over[e]	Not permitted
Rabies and other lyssaviruses	Not permitted	5 years and over[f]	Not permitted	Not permitted	Not permitted	Not permitted[g]	Not permitted	Not permitted
Rotavirus	Not permitted	Not permitted	Not permitted	Not permitted	5 years and over	Not permitted	Not permitted	Not permitted

[a] In line with NT immunisation schedule
[b] Excludes immunisation with immunoglobulin
[c] Excludes travel purposes unless pharmacist/pharmacy is participating in the Victorian Community Pharmacist Statewide Pilot
[d] For 5-10 years and over, pharmacist must have additional paediatric authorisation with the Tasmanian Department of Health.
[e] Mandatory completion of the additional training module: Monkeypox vaccination eLearning module. Excludes vaccination for travel purposes other than those people recommended for vaccination as listed on the Department of Health's Monkeypox webpage
[f] Intramuscular injection pre-exposure prophylaxis treatment only for people who are not immunocompromised
[g] Authorised pharmacist immunisers may administer rabies, typhoid and Japanese encephalitis vaccines to an individual aged 10 years and over if the vaccine was prescribed by a medical or nurse practitioner on or after 6 March 2023 and remains valid (within 12 months of prescribing).

[134] Adapted from Pharmaceutical Society of Australia. Pharmacist administered vaccinations. Available from: https://www.psa.org.au/state-vaccination-regulations/#1701652913910-6d14eba7-c9ec

The NRAS has been pivotal in improving national consistency in regulatory practice and application of 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 limited evidence or focus on current practice and whether profession-specific scopes of practice are meeting community need. Further, regulatory practice under the remit of NRAS excludes any profession not registered under the NRAS. This risks a siloed approach to the consideration of a change to established scopes of practice, the potential conflict of professional interests over the public interest and fails to recognise the strength of a holistic and consumer-focused approach to care delivery.

National Boards face significant challenges in progressing proposals for significant practice change, including the need to access extensive evidence reviews and undertake public consultation to demonstrate benefit, address risk and obtain agreement and authority to proceed. Consultation highlighted that this inherent rigidity within the system stifles progress and innovation. Ideally, the Boards' role as regulator in proposals to amend standards, codes, guidelines etc in response to innovation and change in workforce or care models should be on the basis of the availability of underpinning quality evidence appropriately compiled to support the case for change. This is not always the case and not infrequently resources of Ahpra and the Boards are required to support the preparation of the case, rather than its consideration.

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, Australian, 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.

"For optometrists, when it comes to prescribing oral medications for the purpose of the practice of optometry, it is not State and Territory drugs and poisons laws that are holding back change. Rather, it is the need to secure a decision that allows therapeutically endorsed optometrists to prescribe oral medications for the purpose of the practice of optometry. This decision is made by Health Ministers, based on advice from Ahpra, following a thorough deliberative process by the Optometry Board of Australia, which includes public consultation and consultation with the relevant professions."

Optometry Australia

As highlighted by the NHRA mid-term review,[135] there is a need to view the health system as a more cohesive whole, rather than separate components. This makes sense, given the inter-related nature of health care and the consumer journey which frequently traverses public and private health sectors and often a range of specific settings within each. The review recommends establishment of an independent agency that supports innovation and reform through the identification of emerging issues and application of a long-term view of reforms. Primary care workforce innovation and reform were identified as requiring more systematic assessment and support.

These findings align with the views expressed during consultation.

[135] Australian Government Department of Health and Aged Care (2023) Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report. Accessed 18 July 2024.

"Independent, evidence-informed assessment of innovation will promote new models of care that utilised better workforce planning and utilisation. It will allow that workforce to practice to full scope and within scope. To avoid siloed care and professional competition the process of transferring the use of full scope into practice settings to meet community needs is essential. This will result in multidisciplinary teams that have shared outcomes and collaborative, innovative and efficient patient outcomes incorporating evidence-informed practice."

Australian Physiotherapy Association

Consistent with the NHRA mid-term review and the extensive consultation undertaken as part of this Review, establishment of an Independent Mechanism ('The Mechanism') to support health workforce innovation, reform, planning and excellence is proposed.

Function

The Mechanism would function as a proactive, independent advisory body that provides advice to Ministers, Australian, State and Territory governments, National Boards and regulators to enable objective assessment of evidence in support of significant health workforce innovation, including in relation to scopes of practice. Advice may include legislative amendment, regulatory change and/or funding and payment arrangements.

There is a clear potential role for the Mechanism in housing and maintaining the proposed National Skills and Capability Framework and Matrix, for which an independent development process was strongly supported. The ongoing functioning of the Mechanism would also be supported by the presence of the Matrix as a living document, as detailed further in *Section A1*.

"As... others have argued, re-establishing an autonomous national advisory body that considers new and innovative workforce models and impact on scope of practice is a necessity to address these challenges. As this Issues Paper identifies, autonomy of the agency is essential to avoid conflicts of interest or self-interest that would arise should it be established within an existing body, especially a regulatory body such as Ahpra, or a discipline-specific body such as the Medical Services Advisory Committee. The body would also need the power to influence regulated, self-regulated and non-regulated health care professions, as well as engage with other key agencies across the entire health system..."

Public Health Association of Australia

Structure

The Mechanism would have either a legislative or administrative foundation that enshrines its purpose and requires its findings to be considered as a precondition of actions taken by Ahpra, the National Boards, professional associations and jurisdictions on significant health workforce innovations, including significant system wide health workforce and scope of practice reforms. In providing advice and reporting to Health Ministers (via the HMM), consideration must be given to the recommendations and advice provided by the Mechanism, including for amendments undertaken by government, National Boards and professional associations. Examples of similar bodies include the Medical Services Advisory Committee, an administrative committee, and the Pharmaceutical Benefits Advisory Committee, a legislated committee.

The Mechanism would have authority to provide advice, with the expectation that this be considered and inform decisions about health workforce innovation, including scope of practice. It would require stable and ongoing resourcing to undertake its functions, including proactively commissioning independent evidence sourcing and analysis.

Principles

The following principles would underpin the work conducted by the Mechanism.

- Independence
- Multidisciplinary, inclusive and representative of a broad range of perspectives including consumers
- Transparency
- Collaborative and consumer focused
- Skills based governance
- Connected to a broad range of consumers, care providers, educators and professions.

Roles

Specific roles of the Mechanism would include:

- **Support excellence and innovation, including new workforce models.** The Mechanism would review and consider established and emerging evidence, from a variety of sources[136] and commission independent evidence, where needed, in relation to proposals from professions, governments and industry that address innovations or significant changes to health workforce. Reviews may focus on emerging roles, new models of care and/or significant modifications to practice scope.
- **Provide advice to support the translation of evidence into practice**, through the consideration of factors required to enable the timely and consistent implementation of evidence-based practice change.
- **Provide leadership to support innovation.** Where evidence supports practice change that meets community need, the Mechanism could provide, through advice and recommendations, leadership to support the consistent and timely implementation of practice improvements.

A bidirectional relationship would exist between the Mechanism and National Boards/professional associations, whereby the Mechanism would both consider requests from and make advice and recommendations to these groups.

In undertaking its role, the Mechanism would focus on supporting collaborative primary care health innovation and workforce planning, including in areas of shared scope, rather than profession-specific, siloed reforms.

Consistent with its focus on evidence-based health workforce innovation, the Mechanism would provide a logical institutional base for areas of workforce reform described in *Sections A1 and A2*. The Mechanism is therefore the recommended entity responsible for developing the National Skills and Capability Framework and Matrix and developing and informing implementation of a primary care workforce development program (as described in *Section A2*).

[136] Evidence sources could include published, peer-reviewed literature, grey-literature from the implementation and evaluation of local practice innovations and First Nations-led research. The Mechanism should acknowledge the significance of research undertaken in specific settings such as rural and remote areas and their potential application to other contexts. Commissioned evidence may include rural and remote areas as settings for innovation.

Composition

A skills-based, consumer-focused approach would be taken to establishing the composition of the Mechanism. Members would be appointed by the Health Ministers and include consumers, First Nations peoples, health professionals, health service providers, and the higher education sector. All members must be independent and not representatives of government, industry or professional organisations.

Intended outcomes

Support for innovation in health care delivery. Using a proactive model, the Mechanism would support innovation and excellence in health workforce design, and development by providing independent, evidence-based advice and supporting the translation of evidence to meet community needs.

Improved responsiveness to legislative and regulatory change. The Mechanism would maintain a constant view of evidence, highlighting emerging needs and roles. This would enable a more dynamic, responsive and forward-thinking approach to health workforce design, development and planning through early assessment of changes to relevant legislation and regulation, higher education planning and professional practice standards.

Improved transparency and public trust. The Mechanism would enable greater transparency in evidence-based decision-making about scope of practice, including the considerations on decisions to significantly change a scope of practice in line with community need. This improved visibility would contribute to greater trust in the decisions made as well as the benefits to the consumer, community, workforce and primary care system.

Enablers

Successful establishment of the Mechanism would require **inclusive engagement and co-design** to ensure the purpose, scope, structure and function are clearly understood and accepted and any risks are carefully considered and mitigated.

Establishing a positive, trusted identity for the Mechanism would rely on the **maintenance of its independence** and the contribution of advice and recommendations consistent with its role in providing independent and expert advice.

To enable **effective governance**, it is important that all members are appointed on an independent basis and not as representatives of a specific organisation or profession. An inclusive membership is critical, including consumers, First Nations peoples, health professions and providers and the higher education sector. The Mechanism will report directly to Ministers.

Adequate resourcing for the development, establishment and maintenance of the Mechanism, including the ability to proactively commission new evidence, as well as engage expert evaluation of submissions brought forward to the Mechanism for consideration.

Change management would include early and ongoing communication with consumers, government and key stakeholder groups and the development of comprehensive guidance to support optimal use of the Mechanism. This guidance must be publicly available to ensure equity of access for all groups in the consideration of new evidence. Change management would need to focus also on facilitating a culture change to understand the role of the Mechanism and consult appropriately to inform decisions.

The Mechanism may be enabled by, and have an ongoing role in managing and maintaining, the proposed National Skills and Capability Framework and Matrix.

Recommendation 9

Establish an Independent Mechanism to provide evidence-based advice and recommendations to the Health Ministers' Meeting (HMM), Ministers, government and key stakeholder groups in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope, that:

- Are high risk, or
- Offer significant improvements to service access, consumer experience or productivity.

9.1 Independent Mechanism to hold responsibility for developing the National Skills and Capability Framework and Matrix (Recommendation 1) as a priority initial activity.

Implementation

Development of the Mechanism and terms of reference. The principles, role, scope, function, resourcing and authorisations of the Mechanism should be established and agreed, and the legislative or administrative structure of the entity defined. **(Short-term)**

Governance and appointment of members. Governance structure established wherein the Mechanism reports directly and is accountable to Ministers, and members are independent (not representatives of particular organisations). Ministers are responsible for appointing members of the Mechanism. **(Short-term)**

Members of the Mechanism should be appointed in parallel with the above. Members should be independent of government and professional organisations. Appointees should bring skill, expertise and/or experience, rather than be appointed based solely on profession. Membership should comprise a breadth of knowledge and experience, including consumers, First Nations peoples, rural and remote consumers and health care providers. **(Short-term)**

Engage institutions and sector. Engagement with all major institutions and decision-makers who will interface with the Mechanism, to ensure its role and authorisations are understood. The expectation that the advice of the Mechanism be considered in making decisions related to health innovation and/or scope of practice for primary care providers should be written into the guidelines for National Boards. **(Short-term)**

Theme C: Funding and payment policy

Two reform proposals are presented below relating to funding and payment policy:

C1. Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice

C2. Direct referral pathways supported by technology

C1. Funding and payment models enable and support health professionals in 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. Payment rules that set which health professionals are funded and paid to deliver certain activities have a practical impact of limiting the scope of practice of those who are excluded. Rules also specify which activities are funded for those health professionals who are included in the payment program and influence the extent to which professionals collaborate as multidisciplinary care teams. The availability of appropriate and flexible funding and payment models is crucial to support health professionals working together and to their full scope of practice.

Introducing more flexible payment models to complement the predominantly fee-for-service payment model in primary care would support primary care professionals to better meet consumers' changing health care needs (particularly complex health needs) consistent with the policy intent of *Strengthening Medicare*. This approach more effectively funds primary care professionals and multidisciplinary care teams to work together, and individually, to their full scope of practice, and would particularly benefit rural, remote, First Nations and underserviced communities to access primary care where the workforce is more limited.

The importance of the multidisciplinary care team has been recognised through government policy reforms such as *Strengthening Medicare*, the Workforce Incentive Program (WIP) and PHN commissioning programs for multidisciplinary care. There is opportunity to better enable health professionals to work together in multidisciplinary care teams to meet the needs of their patients by addressing funding and payment barriers to multidisciplinary activities. A separate review of incentive payments, the *Review of General Practice Incentives*[137] is currently underway and is expected to recommend changes to current general practice payment arrangements.

Primary 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.

Broad based, risk adjusted blended payment for primary care

The blended payment is proposed to progressively combine and refocus 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 the *Strengthening Medicare* reform direction of a primary care system serviced by multidisciplinary care teams working to their full scope of practice. This payment would be available to practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), PHNs and ACCHOs to support a flexible mix of health services that meet the local health needs of their registered population.

N.B: The term 'practice', when used in this section to describe where the flow of blended payments is held and managed, refers to the range of entities described above.

[137] Australian Government Department of Health and Aged Care (2024) Review of General Practice Incentives. Accessed 1 October 2024.

The long-standing fee-for-service arrangement in Australia is the principal payment model for the primary care sector. This payment mechanism incentivises episodic, high-turnover care because the number and type of episodes of care determines the amount paid to the health care provider. This payment system does not incentivise and support the multidisciplinary model of care required for consumers with complex conditions requiring co-ordinated and continuous care. Currently, the revenue stream for primary care in Australia is overwhelmingly derived from fee-for-service at a ratio of around 90:10 (fee-for-service to other payment types).

The broad based, risk adjusted blended payment would not seek to replace in entirety the existing fee-for-service arrangement. Under this proposal, fee-for-service would continue to be a major payment arrangement for the primary care sector. This recognises that by volume, most care delivered in primary care is appropriate for fee-for-service payment, in that much of it is episodic, single-discipline and uncomplicated in nature.

Rather, the intent of this blended payment is to enable an increase in the mix of care and support options available for those consumers with complex conditions, who are currently not well supported by the existing predominantly fee-for-service arrangement. The policy intent is to progressively shift this towards a ratio of funding with a more significant blended funding component reflecting the size and growth in the population of consumers with more complex care needs.

Over time, the government funding for primary care - at a national level - should shift towards a 60:40 split, whereby around 60% of Australian Government funding is delivered through fee-for-service and 40% through the new blended funding mechanism and other models. This policy direction is consistent with the *Primary Health Care 10 Year Plan (2021)*[138] and *Strengthening Medicare*. This shift will be associated with an expected increase over time in consumers registering with a practice (as defined above) in order to obtain the benefits of continuity and co-ordination of care. MyMedicare is the available mechanism for registration, and the blended payment proposed in this Review is linked to practice registration. Blended payments made to a practice would thus reflect the risk profile of the consumers registered.

It is noted that the split at the individual service level would be highly dependent on specific community needs and that, for some areas, the proportion of blended funding is and would continue to be higher than the 40% observed at a national level.

For this reason, the blended payment is proposed to be applied through a dedicated risk-adjusted mechanism, as detailed further below.

The proposed blended funding mechanism represents an overall rebasing of Australian Government investment in primary care. It is also proposed that this rebasing is accompanied by a new transitional payment to practices. This additional payment increases the overall level of Australian Government funding and payments and supports the transition to the 60:40 target over a seven-year period. The transition payment will:

- Enable smooth implementation and change management at the practice, profession and population levels
- Make appropriate and equitable adjustments at the fundholder level for historical underutilisation of MBS and other primary care programs due to long-standing GP, nursing and allied health shortages
- Incentivise establishment and spread of innovative multidisciplinary models of care including rural generalists, nurse-led, allied health-led and midwifery-led clinics, and advanced remote service delivery models to better serve rural, remote, First Nations and underserviced populations.

It is not within the scope of this Review to specify the overall quantum of additional investment in primary care to be made by government. However, it is within the scope of this Review to advise how future investments and other policy initiatives by government can best contribute to the *Strengthening Medicare* goal of health professionals working to their full scope of practice in multidisciplinary teams in the primary care sector. On the latter, the advice of this Review is clear – invest proportionally more in blended payments, and proportionally less in fee-for-service payments.

Of relevance here is that the current policy setting for the MBS in the primary care setting is as a largely uncapped, demand-driven program underpinned by a special appropriation. Its principal limitation on growth is the availability of GPs to provide services which draw down the MBS revenue. If there was, for instance, a 10% increase in GPs, triggering a corresponding 10% increase in MBS payments, the current setting simply allows for that funding to be made available to the primary care system without any need for change in government policy.

[138] Australian Government Department of Health and Aged Care (2022) Australia's Primary Health Care 10 Year Plan 2022–2032. Accessed 1 September 2024.

The proposed blended payment would commence with a transition payment and staged repurposing of existing payments over a seven-year period to bring the national base to 60:40. Thereafter, annual Budget cycle investments and indexation would apply to the revised base.

At a broad level, the blended funding would better value and support the wraparound aspects of primary care, and important (though less face-to-face) clinical work such as care planning and coordination. Importantly, it is intended to better support and enable health professionals working to their full scope of practice in multidisciplinary teams within and across practices, which would be less reliant on GP face-to-face throughput to draw down MBS funds to generate revenue.

Decisions about the application of the blended payment would be made at the practice level (potentially in coordination with the PHN) based on community needs and workforce availability. There would be a requirement that practices use the funding to access and coordinate more substantially with a broader multidisciplinary health care team, including commissioning, contracting, employing or otherwise paying for allied health, nursing services and midwifery services as needed for registered patients.

The introduction of outcomes monitoring and evaluation, detailed further below, would help to ensure local decision-making is consistent with the policy intent of increased multidisciplinary care options delivered by health professionals working at full scope of practice.

"I think block funding is the only way forward for rural - not only for medical but all practitioners. Overnight, my GP would shift to a system of triaging patients using their highly competent nursing. In respiratory illness season, at least 7 out of 10 patients could be triaged through this system - the whole incentive moves elsewhere."

Consultation participant

The proposed risk-adjusted blended payment funding model would build on existing good practice examples of primary care in rural and remote settings, which were validated through stakeholder consultations and submissions. Specific examples of existing funding models to be drawn upon include:

- ACCHOs, which provide effective culturally safe primary care under a blended model (mix of MBS fee-for-service, grant and program funding), such as the exemplar Nuka model which forms the basis for multidisciplinary team-based care at the Institute for Urban Indigenous Health (see the Case study: Institute for Urban Indigenous Health).)
- Section 19(2) exemptions (Health Insurance Act) whereby funding flows via authorised MBS billing to LHNs and ACCHOs
- Block funding of primary care type services provided by LHNs through the NHRA
- PHN commissioning funds, with an example provided below.

Example: Primary Mental Health Care Flexible Funding Pool[139]

In 2019, the Australian Government released guidance on 'stepped care' as part of the PHN Primary Mental Health Care Flexible Funding Pool. The PHN Primary Mental Health Care Flexible Funding Pool provides a consolidated funding source from which PHNs can commission primary mental health care services to best meet their regional needs. The funding provided is capped and requires PHNs to make best possible use of all available services and resources.

Stepped care is a framework to guide PHNs in their role in planning, commissioning, and coordinating mental health services. It involves person-centred care, moving away from a provider driven approach to designing a system with consumers and carers at the centre. This approach aims to provide a continuum of primary mental health services which will ensure a range of service types and choices for consumers. This stepped care approach has five levels: self-management, low intensity services, moderate intensity services, high intensity services, and acute and specialist community mental health services.

This framework utilises a multidisciplinary approach to mental health service commissioning that supports consumer choice. The multidisciplinary team includes the role of GPs, psychiatrists and mental health nurses, as well as appropriately trained and qualified allied mental health professionals, such as psychologists, social workers, occupational therapists and Aboriginal and Torres Strait Islander Health Workers and Health Practitioners.

It is essential for providers of mental health services commissioned by PHNs to be able to refer clients to alternative services delivered by a different type of workforce when there are clinical needs that fall outside their scope of practice. In this way, services provided complement each other and target service gaps at a population level or the needs of specific groups or consumers.

It is proposed that the seven-year transition to the 60:40 model, supported by the transition payment, commence implementation in communities facing the greatest primary care access and equity challenges. Current fee-for-service payment models do not readily support innovative, effective, localised care models that are needed in disadvantaged communities. Appetite, readiness and incentive for change in these communities is also higher than in better serviced communities, adding to the reasons for early design, implementation and adoption. Priority communities include:

- Rural and remote regions (MMM 5-7)
- ACCHOs
- Underserviced regional and outer metropolitan areas
- Other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserviced communities and population groups.

Private health insurance general (Extras) cover is also an important source of revenue for (non-medical) primary care services. Most relevant in this context is its support for a wide range of allied health services and chronic disease management programs funded through private health insurance (PHI). The Australian Government, through its policy, regulatory and program responsibilities for PHI, should have significant interest in ensuring that all policy levers in the primary care sector are aligned with *Strengthening Medicare*. This Review is not proposing that funding support for the blended payment should include PHI arrangements. However, it is important that the overall design of the blended payment is cognisant of the important current and potential role played by PHI, that it aligns and is leveraged where appropriate with this aspect of *Strengthening Medicare*, and that the PHI sector be actively involved and consulted in the design and implementation process.

[139] Australian Government Department of Health (2019) PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped Care. Accessed 18 July 2024.

Conditions of the blended payment

For access to the proposed broad-based, risk-adjusted blended payment, there are several conditions required to be met:

- Patients must be registered with the fundholding practice through MyMedicare.
- All participating health professionals must be part of a broadly defined multidisciplinary care team or clinical network, as described below.
- Digital infrastructure should be adopted to accommodate clinical team processes such as secure messaging, health information exchange, instant event notifications, results reporting etc, and integrate with My Health Record.
- Access is provided to a broad range of health professional services, not just GPs and primary care nurses, based on the need of the registered population.

Those who would be eligible as fundholders include practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), PHNs and ACCHOs. The fundholder would be responsible and accountable for payment of care initiation, with funding flowing to other members of the multidisciplinary care team who deliver care autonomously, consistent with 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.

The broad definition of the multidisciplinary care team is intended to be inclusive of different care team arrangements, recognising these differ at a community, service and even individual consumer level. The multidisciplinary care team, as defined to meet the criteria for access to this blended payment, would need to be part of a common clinical community, although not necessarily operating under the same roof. Individual health professionals or groups of health professionals may be members of multiple teams, especially when their area of practice is highly specialised or not evenly geographically distributed.

The work underway supported by the *National Digital Health Strategy 2023-2028*[140] to develop a National Provider Directory will support health professionals to define their membership to a multidisciplinary care team. It is acknowledged that a range of existing digital health technologies are currently in use to enable communication across local primary care teams. These would be expected to meet the digital infrastructure criteria (including secure messaging, instant event notifications, results reporting, and My Health Record connectivity) in order for multidisciplinary care teams to be eligible for the payment. This may involve uplift of local digital pathways, in some cases, to meet this eligibility criteria.

Participation for practices is assumed to commence voluntarily, although in the medium-term all practices serving the needs of consumers with complex care needs will become part of the new blended payment arrangements.

Risk adjustment of the blended payment

The blended payment would be risk adjusted based on individual registered patients' likely health care needs. This would result in a pool of funds held at the practice level based on the registered practice population. In areas of chronic shortage of GPs, or where traditional mainstream primary care practices are not viable, there would need to be an alternative registration approach to ensure that consumers in all geographical regions can get access to the blended payment service offering. This could be through State and Territory government health organisations, ACCHOs, PHNs or other health provider organisations. Such an alternative arrangement can adjust for entrenched underutilisation in historically underserviced areas. In this way, the implementation of the blended payment should commence with rural, remote and hard to service populations as a priority.

The risk adjustment requires access to an independent, specialised entity (or capacity within an existing entity, such as the IHACPA) to advise the Australian Government on:

- Calculation, adjustment and maintenance of the risk stratification
- Prospective pricing adjustments, and indexation.

The above risk adjustments are intended to reflect the different need profiles of different communities, and the higher complexity of need in particular communities. Acknowledging historical under-resourcing in some areas, the risk stratification will need to be determined through a combination of metrics, including age, sex, disability, rurality, Aboriginal and Torres Strait Islander status, health service utilisation (actual or predicted) and measures of socioeconomic disadvantage. Reliance on past service use data alone is not considered an appropriate metric because it does not account for current underutilisation of services due to a range of consumer access barriers.

[140] Australian Digital Health Agency (2023) National Digital Health Strategy 2023-2028. Accessed 18 July 2024.

In addition, payment design will need to incorporate compliance and performance evaluation metrics. A set of key performance indicators will need to be developed specific to this payment, taking risk stratification into account, and incorporated into compliance arrangements and ongoing performance evaluation mechanisms.

"Start remote and go in towards the cities. So, you can draw first tranche as MMM5 to MMM7 – it needs to be big enough to create a movement and success and evidence. Digital might still be an issue, but if it works in remote it works everywhere else."

Consultation participant, expert advisory committee perspective

The new blended payment mechanism is also proposed to be progressed into a new reform schedule of the NHRA as part of the current round of negotiations. This is intended to enable appropriate participation by and eligibility for State and Territory LHNs, and the necessary interface with PHNs. In particular, it has relevance for recommendations made in the NHRA mid-term review final report:[141]

- Embedding workforce and digital health as key enablers
- Establishing a dedicated Schedule in the NHRA for improving equitable access to health care services in rural and remote areas, and
- A focus and platform for intersectoral collaboration.

Bundled payment for maternity services

It is common for a consumer accessing maternity care to move across primary care and acute care at relevant parts of a normal maternity care pathway, including newborn care. The introduction of a bundled payment for maternity services, including traditional medically led, GP shared care and midwifery continuity of care models as defined care pathways, is intended to fund and enable midwives, GPs and other medical specialists to work to their full scope when they practice across the primary and hospital care parts of the health care system. These currently operate under separate funding arrangements which can work against optimal woman-centred care models. The bundled payment is proposed to have both public sector and private sector models.

The bundled payment would be inclusive of, and apply to, more than one form of maternity services, e.g. maternity services delivered via a midwifery continuity of care model, a more traditional midwife plus medically led model, or a GP shared care model. These maternity care service models are assumed to involve and incorporate all the necessary clinical and care support components of the episode. This reform was also observed by consultation participants as a potential enabler of Birthing on Country[142] models. For this to bear out, consideration of the conditions attached to the payment will need to be inclusive of different birthing teams and settings associated with this model.

[141] Australian Government Department of Health and Aged Care (2023) Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report. Accessed 18 July 2024.
[142] Australian Government Department of Health and Aged Care (2023) Birthing healthy and strong babies on Country. Accessed 1 August 2024.

Insights from the Independent Hospital and Aged Care Pricing Authority review

A 2017 IHACPA review of bundled pricing for maternity care found:[143]

- Bundled payments have been implemented in many international jurisdictions for various conditions, with bundled maternity payment schemes identified in England, Canada, New Zealand, and some United States jurisdictions.
- Midwifery continuity of care models, such as that implemented in New Zealand through a midwife-led model, are associated with increased consumer satisfaction, lower rates of interventions (such as caesarean section, instrumental births, induction and epidurals) and lower cost.
- Bundled pricing for maternity care could drive a change in how and what services are delivered, with the impact dependent on the scope of patients, stages of care and services in the bundle, as well as the degree of risk adjustment and the pricing approach. It has the potential to drive innovation depending on the services that are included in the bundle.
- A single consistent price for the non-admitted portion of care across all patients is not appropriate due to the variable risk (and costs) seen across patients. Risk adjustment (e.g. based on Diagnostic Related Groups of the admitted care episode) is therefore recommended.
- Some exclusions are appropriate where consumers would not stand to benefit from the incentives of a bundled price (such as consumers with very complex health needs and neonatal intensive care).
- The primary barrier to delivery in Australia was the lack of a unique patient identifier in IHACPA administrative datasets, which precluded its implementation at the time of the 2017 report.

The payment is required to be risk-stratified to an extent to minimise the risk identified in the IHACPA review of *"potentially limiting access to care for patients whose costs exceed the bundled payment or to maximise the financial benefit to the provider"* [page 6],[144] which applies not only to maternity bundled pricing but to bundled pricing as an approach more generally. There are a range of well-known risk factors that apply to maternity care, which must be factored into the bundled payment, for example through risk adjustment based on Diagnostic Related Groups of the admitted care episode as recommended by the IHACPA review.

Public sector model

In the public sector model, the bundled payment would be made to the LHN or equivalent, via the existing National Weighted Activity Unit payment arrangements determined by IHACPA and paid via the National Health Funding Body. The LHN or equivalent would be responsible for ensuring that all the necessary clinical and care support components covered by the bundled payment are secured, managed and provided commensurate with national safety and quality standards. This includes the management of employment or contacting arrangements with providers of care.

Private sector model

In the private sector model, the change would be more significant. PHI is regulated under the *Private Health Insurance Act* and approved policies are generally grouped into two classes – Hospital and General cover. *Hospital cover* is for services delivered in a hospital or equivalent setting and is typically linked to care provided by a medical practitioner and rebated by MBS items for that care. *General cover* is usually for services provided outside the hospital setting, and for which there is no MBS item available for that care. General cover policies do not cover gaps between an MBS schedule fee and the fee paid by the patient.

There are two broad streams of billing under hospital policies. The first is for payments raised by medical practitioners and these are covered by a combination of MBS, gap cover and out-of-pocket cost. PHI policies cover some, or all of these costs. All patients receiving care through a private hospital and if reimbursable under PHI Hospital cover are admitted to the hospital by a named medical practitioner. Under the midwifery continuity of care model, it is proposed that the admitting health professional is an endorsed midwife.

[143] Independent Hospital Pricing Authority (2017) Bundled pricing for maternity care: Final Report of IHPA and the Bundled Pricing Advisory Group. Accessed 18 July 2024.
[144] Ibid.

The second stream is for charges associated with services provided by the private hospital to the patient. This is typically a consolidated bill to the patient, which is covered by the PHI hospital policy, usually with no out-of-pocket fees. Out-of-pocket fees may still apply for front end deductibles/excesses (i.e. agreed by the PHI and the policy holders), or for exclusions, i.e. services not covered under the respective policy.

In addition, there are a range of services provided to women during the pregnancy and post-natal phases that are primary care in nature. These are typically associated with services covered by MBS items, e.g. consultation, imaging and pathology fees, but are not part of the hospital episode. As such, these are not covered by PHI hospital or general cover policies and will attract a fee.

The proposed private sector bundled payment would group the hospital and primary care components into a single payment to cover the full episode of care i.e. pregnancy, birthing and post-natal care. This could support and align with a midwifery continuity of care model, provided by an endorsed midwife, or a GP shared care model.

Legislation and regulation changes would need to be made to the *Health Insurance Act*, *Private Health Insurance Act* and potentially other State and Territory acts to:

- Recognise the new hybrid PHI product (hospital plus primary care)
- Enable the MBS items to be bundled
- Authorise the admission of patients to a private or private hospital by an endorsed midwife.

There was, overall, a broad consensus across consultations that a bundled payment for maternity services would have significant value in resolving scope of practice issues which arise across the midwifery care journey. Moreover, support was voiced for the bundled payment model to be extended to other conditions with relatively predictable pathways (such as diabetes and some commonly treated cancers). Therefore, the maternity bundled payment should be seen as an example which can be followed by broader rollout of the model, where appropriate.

Single payment rate for like services within common scope

Within the existing MBS and other arrangements, Issues Paper 2 included a proposal to adjust payment rates to introduce parity across professions undertaking effectively identical service delivery, applied to a limited number of specified activities which fall under the current scope of multiple professions.

Through the stakeholder consultation process for Issues Paper 2, consensus was not reached on the benefits and practicalities of this reform option. The reform option was seen by some stakeholders as contributing to interprofessional equity, as well as to remove disincentives to specific activities being delivered by non-medical professionals. However, concerns were equally voiced that this reform option did not adequately consider or value the complexity of primary care consultations, in that they are typically not limited to a single activity. Additionally, there were concerns about devaluing the additional education and training undertaken by some health professions, which is reflected in the variable payment rates across professions for similar services. For this reason, services representing similar scope were argued not to be truly 'like' in nature, making this reform option less clear cut.

Furthermore, the probable implementation avenue for this reform option, involving increasing all MBS payments for 'like services' to the highest level, would likely have a significant inflationary impact on the cost of delivering primary care. Meanwhile, the alternative avenue, which would involve reducing MBS payments to a 'lowest common denominator', is not palatable to most health professions and may represent a real drop in revenue for health services.

The need for better utilisation of all members of the multidisciplinary care team was strongly emphasised throughout all consultation phases and underpins the purpose of this Review. In light of this, the proposed risk-adjusted blended payment is emphasised as playing a critical role in enabling multidisciplinary team-based care, by introducing a flexible payment to fund holding practices. This is the recommended medium to long-term pathway for payment reform, as well as the preferred investment vehicle for future growth in primary care to support better access to multidisciplinary care and health professionals working to their full scope of practice.

"The proposal for a single payment rate doesn't reflect the reality of delivering clinical care. People rarely present with just one issue and patients often use a service like a vaccination to ask other questions of health care staff. There is a risk with this reform that patients will either not seek this additional care if they don't believe they need to, …or will request advice that is beyond the scope of the service provider to provide."

Consultation participant, peak organisation perspective

Intended outcomes

Reduced reliance on highly episodic care. Introducing blended and bundled payments are intended to value, enable and support those aspects of primary care which are not currently well accounted for by the fee-for-service mechanism. In particular, health professionals are expected to 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.

"Having the funding to spend time building relationships, building reciprocity, to work with the whole community is so vital to making an actual impact. Individual [fee-for-service] funding takes that away so much."

Consultation participant, rural and remote perspective

Greater flexibility over the makeup of the health care team. Shifting the balance of primary care payments towards a blended model seeks to reduce reliance on GPs to draw down MBS funding. With the introduction of a blended payment, practices will have greater flexibility to employ or engage different health professionals to contribute to the multidisciplinary health care team and work to their full scope of practice. This is intended to result in a stronger system of multidisciplinary care teams with the right combination of scope and skills, built around the needs of local registered practice populations.

Improved access to appropriate primary care for people with complex health needs. Shifting the system towards a risk-adjusted blended payment model which acknowledges the complexity of care required, over time, will lead to a primary care system built more around meeting complex health needs. These consumers, who represent the area of greatest need, stand to benefit the most from an access standpoint. They will be better able to access longer appointments and care which spans multiple disciplines, amounting to improved access and continuity of care.

Impact on multidisciplinary care teams

Services are, overall, intended to be better enabled to build more sustainable multidisciplinary primary care teams which are genuinely collaborative and built around consumer need.

The blended payment better values broader members of the multidisciplinary team members and their contributions to primary care, leading to enhanced employee satisfaction and retention.

Acknowledging and 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.

"I am in support of the blended/block funding model for recognising full scope of practice for Aboriginal and Torres Strait Islander Health Practitioners, to enable the provision of cultural advice and care and education, healing and support benefits. Those models offer much more scope for supporting those practitioners in the delivery of that care outside of ACCHOs."

Consultation participant, First Nation perspective

Enablers

Cultural change management will be required at a systems level to communicate the intent behind the blended payment. A significant focus on culture and leadership will be needed to drive the multidisciplinary team-based direction of the primary care system more broadly, including down to the service level. This will be important to support the balanced and fair use of the blended payment to benefit all members of inclusive multidisciplinary health care teams and avoid reinforcing the status quo where parts of the primary care system are underutilised.

Relatedly, reinforcing **cultural safety** will be critical to promote and acknowledge the contributions made by First Nations health professionals, particularly Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, to multidisciplinary team-based care. This is equally important for the application of the blended payment to promote inclusive multidisciplinary care teams, as for the bundled payment for midwifery continuity of care, which must support Birthing on Country and other emerging models designed to meet the needs of First Nations families and communities.

While robust **digital health systems** enabling interprofessional communication are a condition of the blended payment, the intention of this reform proposal is not to delay implementation until an appropriate single digital platform is made available across the primary care system. Rather, health services should continue to use existing systems to communicate with their multidisciplinary care teams and should consider this as an impetus to uplift existing infrastructure where required. As the digital health agenda continues to be progressed at a national level, there are likely to be specific enablers (such as the National Provider Directory proposed as part of the development of a National Health Information Exchange) which will be of utility to the ongoing scaling of the blended mechanism.

Recommendations

Recommendation 10: Introduce a new blended payment to enable access to multidisciplinary health care delivered by health professionals working to their full scope of practice in primary care. This new payment would be supported by a significant growth in investment in primary care and would shift the mix of Australian Government payments for primary care over time from a 90:10 fee-for-service: blended payment to 60:40 (at an aggregate national level).

10.1 Fundholding entities for the new blended payment include practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs) to fund and support a flexible mix of health services to meet the local health needs of their registered population.

10.2 Establish access requirements for the blended payment as follows:

- Patients must be registered with a health care provider via MyMedicare
- Participating health professionals must be part of a team [broadly defined] or clinical network
- Digital infrastructure must be adopted to enable clinical team processes such as secure messaging, instant event notifications, results reporting and articulation with My Health Record
- Affordable access for registered patients to an appropriate suite of multidisciplinary health services provided by health professionals operating at full scope.

10.3 Progressively incorporate a range of existing Australian Government, practice, program, Medicare benefits Schedule (MBS) and PHN commissioning payments into the blended payment.

10.4 Introduce a new practice level transition payment to ensure that the move from 90:10 to 60:40 ratio is supported by real growth in primary care investment which:

- Enables smooth implementation and change management at the practice, profession and population levels
- Makes appropriate and equitable adjustments at the fundholder level for historical underutilisation of MBS and other primary care programs due to long-standing General Practitioners (GP), nursing and allied health shortages
- Incentivises establishment and spread of innovative multidisciplinary models of care, including rural generalists, nurse-led, allied health-led and midwifery-led clinics, and advanced remote service delivery models, to better serve rural, remote and underserviced populations.

10.5 Establish an independent, specialised mechanism, or utilise an existing entity (such as Independent Hospital and Aged Care Pricing Authority) to advise on the pricing and payment levels of the blended payment. The mechanism would provide ongoing advice to the Australian Government on

- Design, calculation and maintenance of risk stratification for the blended payment, based on the profile of registered patients at the practice population and fundholder level
- Prospective pricing adjustments and indexation of the blended payment.

10.6 For historically underserviced areas with minimal or no access to MBS billing, GPs and health professionals implement an alternative registration model to ensure equitable access to the blended payment as the primary payment mechanism for Australian Government primary care programs.

10.7 Incorporate the blended payment model into a new reform schedule of the National Health Reform Agreement (NHRA) to enable appropriate participation by and eligibility for State and Territory Local Health Networks (LHNs) and PHNs.

10.8 Implement the blended payment model in a staged program over seven years commencing with the following priority areas:

- Rural and remote regions (Modified Monash Model 5-7)
- ACCHOs
- Underserviced regional and outer metropolitan areas
- Other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserviced communities and population groups.

Recommendation 11: Introduce a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and public hospital settings.

11.1 Introduce a private sector version of the bundled payment for maternity care. Amend the *Private Health Insurance Act* and *Health Insurance Act* to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings.

Implementation

Design a new blended funding and payment model for primary care multidisciplinary teams. Fundholding entities for the new blended payment include practices, practice groups, primary care provider organisations (including State and Territory Government entities where appropriate), PHNs and ACCHOs to fund and support a flexible mix of health services to meet the local health needs of their registered population (based on MyMedicare registration). The blended payment will incorporate existing funding sources, with appropriate adjustments at the fundholder level for historical underutilisation due to long-standing GP shortages. **(Short-term)**

Engage with NHRA negotiations to introduce a new blended funding and payment model for primary care as part of priority reform negotiations. Incorporate the blended payment model into a new reform schedule of the NHRA to enable appropriate participation by, and eligibility for, State and Territory LHNs. **(Short-term)**

Establish access requirements for the blended payment. Patients must be registered with a health care provider via MyMedicare, participating health professionals must be part of a broadly defined clinical team or clinical network, and digital infrastructure must be in place to enable clinical team processes such as secure messaging, instant event notifications, results reporting and articulate with My Health Record. **(Short-term)**

Establish or utilise an existing independent risk stratification mechanism. This will be responsible for designing, calculating and maintaining the risk stratification method for the blended payment, as well as determining prospective pricing adjustments and indexation of the Commonwealth payment. It may sit within an existing entity, such as IHACPA. **(Short-term)**

Design outcomes measurements and evaluation framework for the blended payment. Design appropriate key performance indicators to enable compliance monitoring and ongoing evaluation of the blended payment. **(Short-term)**

Design a model of bundled payment for maternity service models. Engage with professional and other peak bodies, private hospitals, jurisdictions, funders, private health insurers 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 IHACPA is to recommence earlier exploratory work undertaken to develop a bundled payment for midwifery continuity of care. This will also need to be considered in the context of potential changes to the private health insurance (PHI) risk equalisation pool i.e. inclusion of private obstetric services. **(Short-term)**

Commence targeted rollout of the blended funding mechanism in selected regions. Initiate rollout with a concentrated launch for regional and remote regions in MMM 5-7, on an opt-in basis, and evaluate effectiveness. The second phase of the rollout will take place in selected metro areas based on inherent capacity of providers and relative need of underserviced communities. **(Medium-term)**

Broader implementation of the blended funding mechanism. Based on the evaluation of the targeted rollout, fully implement the blended funding mechanism over a seven-year program. **(Medium-term)**

Staged implementation of bundled payment for maternity services. Commence rollout in selected rural, remote and metro areas to evaluate effectiveness. Based on the evaluation of the targeted rollout, fully implement the model of bundled payment for midwifery continuity of care across the health system. **(Medium-term)**

C2. Direct referral pathways supported by technology

Summary

Payment rules about which health professions can provide referrals to non-GP medical specialists are tightly defined under the *Health Insurance Act 1973* (Health Insurance Act) and associated regulations. Under these rules, consumers referred to non-GP medical specialists, including imaging or pathology, cannot receive MBS benefits for that service unless the referral was provided by a defined health professional under specified circumstances. Referrals made by nursing, midwifery and allied health professionals to non-GP medical specialists are highly restricted. Such restrictions are more through application of MBS rules rather than by limitations on scope of practice of the referring health professional. In such instances, the referring health professional is required to direct the consumer to a GP who then makes the referral to the non-GP medical specialists. This is a feature of the 'GP gatekeeper' model.

Notwithstanding the very broad scope of practice of GPs and their role in making such referrals, in certain circumstances MBS rules also apply to some referrals to non-GP specialists made by GPs, e.g. for certain diagnostic procedures such as magnetic resonance imaging (MRI).

Health professionals are not explicitly disallowed from making or accepting a referral to or from another health professional in circumstances outside those defined in the Health Insurance Act and associated regulation, included below. However, outside of referrals provided by specific named professions, these regulations prevent the consumer from being eligible for MBS benefits for the referred service, resulting in out-of-pocket costs by default. In addition, the medical specialist receiving the referral may not accept it as a valid referral, nor would they be required to do so.

Likewise, regulations associated with the Health Insurance Act which define funding rules for referrals to pathology and imaging name specific professions that can provide specific referrals in order for the service to attract an MBS benefit, without which the referral would be invalid.

For these reasons, the Health Insurance Act and associated regulations are broadly understood as defining which referrals are and are not permitted to be made. Consultation evidence reveals this is highly impactful in limiting health professionals' ability to work to their full scope of practice, where they are not explicitly authorised (through attached MBS payment to the consumer) to make referrals which fall within their scope.

HEALTH INSURANCE REGULATIONS 2018 - REG 96[145]

Who can make referral:

(1) A medical practitioner may refer a patient to a specialist or consultant physician.

(2) An optometrist may refer a patient to a specialist who is an ophthalmologist.

(3) A dental practitioner who is approved by the Minister for the purposes of paragraph (b) of the definition of professional service in subsection 3(1) of the Act may refer a patient to a specialist or consultant physician.

(4) A dental practitioner to whom subsection (3) does not apply may refer a patient to a specialist (but not a consultant physician).

(5) A participating midwife may refer a patient to an obstetrician or paediatrician.

(6) A participating nurse practitioner may refer a patient to a specialist or consultant physician.

A highly restricted number of primary care referral pathways allowable under the Health Insurance Regulations are not required to directly involve a GP (e.g. optometrist to ophthalmologist, participating midwife to obstetrician, and nurse practitioner to specialist). The specificity of this list means that the majority of direct professional-to-professional referral pathways are not attached to an MBS payment for the consumer unless the referrer is a medical practitioner. Similarly, regulations specific to diagnostic imaging[146] and pathology services[147] name specific professions that are authorised to make referrals.

[145] Commonwealth Consolidated Regulations (2018) Health Insurance Regulations 2018 - REG 96. Accessed 1 October 2024.
[146] Australian Government. Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020, made under the Health Insurance Act 1973.
[147] Australian Government. Health Insurance (Pathology Services Table) Regulations 2020, made under the Health Insurance Act 1973.

Significant evidence was provided by stakeholders that these funding rules result in the majority of primary care referrals being made by a GP. Significant evidence was heard from stakeholders that these funding rules act in practice as a de facto authorising force to restrict many health professionals' scope of practice in providing referrals that are within their scope of practice to provide. Specifically, stakeholders emphasised that they are restricted from exercising their professional judgment and clinical decision-making competence by referring to a relevant health professional, imaging or pathology, where there is no explicit, formalised pathway for them to do so.

"The GP does need to be collaborated with during the management of their patients. However, common-sense needs to prevail here - general practice is at capacity, straight forward referrals onto specialists from allied health professionals who have made an informed decision about a patient should be permissible under the MBS."

Consultation participant, accreditation authority perspective

For consumers, this creates both cost and time barriers to accessing primary care. This is because, despite receiving care and referral advice from a health professional of their choice, they are often required to undertake a secondary consultation, typically with a GP, to access the required referral. Consultation evidence emphasised that this required pathway has a range of negative impacts for consumers from affordability of care (since consumers would often be required to pay out-of-pocket for an additional GP consultation), to significantly delayed access to care particularly in rural and remote regions without consistent GP presence.

"Direct referral will save time and money to the consumer. Rather than the current back and forth model we currently have."

Consultation participant, consumer perspective

"The more remote, the fewer GPs there are… Let's not forget that in some locations the referrals are already being made, and people working closely in teams, so if they had the ability to inter-refer it'd be quicker wraparound than going to the GP."

Consultation participant, rural and remote perspective

Numerous examples were heard, from both medical and non-medical professions, where the GP sought the advice of the would-be referring health professional in order to complete the required referral documentation for the receiving non-GP medical specialist. These examples were particularly stark where the health professional is relatively specialised in an area of primary care in which a GP would not be expected to have the same depth of experience, such as audiology. Many representatives consulted from the GP profession conveyed a strong view that their role in coordinating referrals was important to avoid the proliferation of unnecessary referrals to specialist services. However, feedback from the consumer group about this potential reform indicated a strong view that fulfilling these administrative requirements is typically experienced as arbitrary, frustrating and a significant barrier to care.

Representatives of the GP profession expressed widely held concerns that if other health professionals were enabled to make direct referrals, they would lose visibility over the care pathway of their patients, resulting in fragmentation. The current digital environment in primary 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.[148, 149, 150] This is reflected as a core aim of *Strengthening Medicare* and the Australian Digital Health Agency's 5-year National Digital Health Strategy. Stakeholder evidence further emphasised the importance of a digital notification of referrals occurring outside the registered practice, to maintain patient safety as well as reinforcing professional trust. Reform is underway to develop the digital environment to support primary care, via enhancement to National Digital Health infrastructure and sharing of information by default as part of the National Digital Health Strategy 2023-2028. This is expected to enable improved communication across the multidisciplinary care team in relation to direct referrals.

"We need to use technology facilitated referral pathways by enhancing shareable record keeping, general information sharing and communication, to enable health professionals to work to full scope of practice in multi-disciplinary care teams."

Consultation participant, peak organisation perspective

Intended outcomes

Expanded direct referral pathways are intended to enable health professionals to make specific types of direct referrals, therefore enhancing their ability to work closer to their full scope of practice. Specifically, this reform proposal is intended to increase interprofessional collaboration and communication by streamlining particular high-volume primary care pathways which are currently subject to unnecessary barriers. It is ultimately intended to strengthen timely consumer access to the primary care services they need.

Expanded referral pathways are proposed to be conditional on the following:

a. The referral is applicable to specific health professionals and circumstances, i.e. clearly linked to referring health professional's 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, preferably via digital mechanisms as available.

c. The health professionals involved in making and receiving the referral are part of a broadly defined clinical team or clinical network.

d. The consumer be made aware of the MyMedicare registration program.

While multidisciplinary team-based care relationships are required as a basis for referrals, formalised care team relationship criteria are not proposed to be incorporated into funding rules. This is in recognition that the requirement for timely notification of the consultation to relevant treating team members would deliver the communication required, while maintaining an appropriate level of flexibility and consumer choice. The PHN may hold a role in supporting the team, network and practice.

A number of appropriate referral pathways emerged from the combined evidence. These are high-volume referral pathways currently subject to requirement of GP involvement despite being clearly understood to fall within the scope of practice of another health professional. Therefore, focusing on these particular referral pathways in the first instance is intended to have significant and material benefit for consumer continuity of care in navigating the primary care system.

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[148] Craig KJT, Willis VC, Gruen D, Rhee K, Jackson GP. (2021) The burden of the digital environment: A systematic review on organization-directed workplace interventions to mitigate physician burnout. Journal of the American Medical Informatics Association. 28(5):985-97. https://doi.org/10.1093/jamia/ocaa301

[149] Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al. (2014) Optimizing scopes of practice: New models of care for a new health care system. Canadian Academy of Health Sciences Ottawa. Accessed 1 August 2024.

[150] Wilson M, Mazowita G, Ignaszewski AP, Levin A, Barber C, Thompson D, et al. (2016) Family physician access to specialist advice by telephone: Reduction in unnecessary specialist consultations and emergency department visits. Canadian family physician Medecin de famille canadien. 62:e668-e76. https://pubmed.ncbi.nlm.nih.gov/28661886/

Proposed first priority additional direct referrals:

Allied health:

- **Physiotherapist, chiropractor, and osteopath referral to orthopaedic surgeon** (when conversative management is not successful or where the patient presents with an acute or serious injury)
- **Audiologist and Speech Pathologist referral to Ear, Nose and Throat (ENT) surgeon** (where an underlying medical condition is suspected as contributing to the speech, hearing or auditory system issues the patient is experiencing and medical treatment, including surgery, may be required)
- **Psychologist referral to psychiatrist** (where the complexity of the person's mental health condition requires additional support and/or is likely to benefit from a medication program or management)
- **Dietitian referral to gastroenterologist** (where the person has a gastroenterological condition requiring specialist support)
- **Diabetes educator referral to endocrinologist** (where there is evidence of poorly controlled diabetes or major hypoglycaemia episodes or other vascular complications)
- **Podiatrist referral to vascular surgeon** (for the management of diabetic foot disease)
- **Accredited hand therapist referral to hand surgeon and plastic surgeon** (where clinically indicated due to fractures, tendon ruptures and other conditions)

Midwife referral to:

- **Obstetric physician** (for Gestational Diabetes Management where there is evidence of gestational diabetes)
- **Maternal Fetal Medicine specialist** (for complex maternal or neonatal conditions, e.g. exomphalos, genetic anomalies)
- **Anaesthetist** (for epidural where required)
- **Psychiatrist** (where there is evidence of perinatal psychosis)

Nurse Practitioner referral to:

- **Psychiatrist** (for complex, high level assessment, treatment and prescribing)
- **Geriatrician** (for cognitive decline, depression and anxiety)
- **Urologist** (for prostate and other urinary tract issues)
- **Gynaecologist** (for reproductive health)

Remote Area Nurse referral to:

- **Non-GP Medical Specialist** (according to need and context)

While the above first tranche of direct referrals have been identified based on likely impact in meeting community need, this area of reform should remain responsive to evidence about where referrals can be made safely and within professional scope of practice. Commencing this reform with a first tranche can also provide guidance on how future additions to the direct referral pathway can be co-designed and considered in a consistent, repeatable, evidence-based process.

Impact on multidisciplinary care teams

Where specific members of multidisciplinary care teams benefit from being able to make more direct referrals, there is potential for benefit across the entire multidisciplinary care team. Each team member would be enabled to work closer to their full scope of practice, and to better recognise both their own and other team members' scopes of practice and expertise (and their limits). There would be reduced reliance on GPs to deliver unnecessary, duplicative consultations for the sole purpose of writing referrals.

In addition, the requirement for notification to be made to the home care team should enhance the prominence of interprofessional communication and collaboration. Utilisation of a standard digital mechanism, implemented in parallel, would likely further reinforce interprofessional communication and trust.

As this proposal reinforces interprofessional communication, an increase in interprofessional trust is expected to follow (particularly if supported by a dedicated program of cultural change).

An important consideration is to balance the need for improved consumer access to referred services with the potential for overburdening services subject to new referral pathways. With expanded referral pathways comes the inherent risk of over-servicing. In particular, stakeholder feedback indicated there was a relatively higher risk of overburdening pathology and imaging services, as opposed to specialist services. Within the specific additional referral pathways proposed to be implemented, there is a reliance on professional trust in individual health professionals to work within their own scope of practice and professional judgement. It is assumed that relevant regulators and National Boards will maintain existing audit strategies and progress communications with relevant professions as required to mitigate this risk. Further, the initial tranche of priority direct referral pathways should be the subject of a detailed co-design process with relevant professions and stakeholders, intended to identify risks and mitigation strategies through a process of interprofessional collaboration. The potential risk of fragmentation of care resulting from expanded direct referral pathways was raised across stakeholder groups. However, the condition of a notification to the consumer's home care team, which includes the consumer's usual GP or general practice, is intended to mitigate this risk. To ensure this, it is important that the notification is provided in a way which is accessible to all relevant members of the multidisciplinary care team. The introduction of enhanced digital mechanisms progressed through the National Digital Health Strategy implementation is expected to streamline how digital notifications are able to be delivered.

"Direct referral pathways should involve the patient's primary care physician GP. It needs to also be an easy efficient referral and correspondence system that is integrated into the existing practice software. Having a separate platform for referrals is time in-efficient and may lead to unnecessary duplication."

Consultation participant, health professional perspective

Moreover, artificial intelligence is increasingly recognised as a tool used to manage clinical risk and could be employed to further review arrangements in addition to existing clinical governance processes within care teams. This could help to mitigate the potential risk of inappropriate referrals or overservicing.

Enablers

Ongoing reform and enhancement of the digital environment across the primary care system was identified as the single most important enabler to progress the intent of this reform option, in fostering increased interprofessional communication and collaboration. As outlined above, while the reforms underway through the National Digital Health Strategy are expected to support the implementation of this reform option, stakeholders emphasised the clear risk of inertia if this reform proposal is assumed to be wholly dependent on the implementation of a particular digital mechanism. Therefore, it is important to consider how this reform proposal can be safely and effectively delivered within the existing digital environment, including existing tools (secure messaging and other platforms) whilst remaining adaptive to new implemented technologies.

Cultural change management is required to accompany a change in funding rules, to ensure new direct referral pathways are consistently understood and respected across professions. This intersects with the broader need for interprofessional understanding, respect and trust more broadly, particularly in cases where there is a perceived deficit.

"Direct referral pathways can only be supported if those you're referring to respect the reasons for the referral and the colleague it is coming from."

Consultation participant, health professional perspective

Recommendation 12

The Australian Government implement new direct referral pathways for consumer access to specified non-General Practitioner (GP) specialist Medicare Benefits Schedule (MBS) items which meet the following criteria:

A. The direct referral made by the health professional is within their scope of practice, and
B. The referral is accompanied by appropriate, timely notification of the consultation to relevant treating team members including the patient's GP, and registered practice via digital mechanisms as available.

In the first instance, these are recommended to include:

Allied health

- Physiotherapist, chiropractor, and osteopath referral to orthopaedic surgeon (e.g. when conversative management is not successful or where the patient presents with an acute or serious injury)
- Audiologist and Speech Pathologist referral to an ENT surgeon (e.g. where an underlying medical condition is suspected as contributing to the speech, hearing or auditory system issues the patient is experiencing and medical treatment, including surgery, may be required)
- Psychologist referral to psychiatrist (e.g. where the complexity of the person's mental health condition requires additional support and/or is likely to benefit from a medication program or management)
- Dietician referral to gastroenterologist (e.g. where the person has a gastroenterological condition requiring specialist support) .
- Diabetes educator referral to endocrinologist (e.g. where there is evidence of poorly controlled diabetes or major hypoglycaemia episodes or other vascular complications)
- Podiatrist referral to vascular surgeon (e.g. for the management of diabetic foot disease)
- Accredited hand therapist referral to hand surgeon and plastic surgeon (e.g. where clinically indicated due to fractures, tendon ruptures and other conditions).

Midwife referral to:

- Obstetric Physician (e.g. for Gestational Diabetes Management where there is evidence of gestational diabetes)
- Maternal Fetal Medicine specialist (e.g. for complex maternal or neonatal conditions, such as exomphalos, genetic anomalies)
- Anaesthetist (e.g. for epidural where required)
- Psychiatrist (e.g. where there is evidence of perinatal psychosis)

Nurse Practitioner referral to:

- Psychiatrist (e.g. for complex, high level assessment, treatment and prescribing)
- Geriatrician (e.g. for cognitive decline, depression and anxiety)
- Urologist (e.g. for prostate and other urinary tract issues)
- Gynaecologist (e.g. for reproductive health).

Remote Area Nurse referral to:

- Medical Specialist (according to need and context).

Implementation

Agree first priority direct referral pathways in-scope for change to MBS payment rules. Commence a co-design process with professions and relevant stakeholders for an initial tranche of direct referral pathways. These are assumed to align with the shortlist identified by this Review (see Recommendation 14). **(Short-term)**

The Australian Government progresses 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. Amendments to MBS items would flow from these amendments. **(Short-term)**

Mitigation strategies to manage risk of inappropriate or unnecessary services via additional referral pathways. Regulators to maintain existing audit strategies and deliver targeted communications which clearly set expectations that direct referrals are made according to health professionals' own scope of practice and professional judgment. These may make reference to existing clinical decision-making tools or ones newly developed for this purpose. **(Ongoing)**

In parallel, development of a National Provider Directory to support health information exchange under the scope of the National Digital Health Strategy reforms will be progressed. Regulators and relevant Boards will be involved in communicating the expectation of all health professionals to make use of this infrastructure to deliver timely digital notifications of referrals to the home multidisciplinary care team. **(Medium-term)**

Staged implementation of direct referral pathways. Commence rollout in selected rural, remote areas and metro areas to evaluate effectiveness. Based on the evaluation of the targeted rollout, fully implement the direct referral pathways across the health system. **(Medium-term)**

Theme D: Enablers and other key considerations

D1. Culture and leadership

Stakeholders provided overwhelming evidence throughout this Review that culture and leadership was the single most critical dependency for achieving change. That is, the reforms proposed in detail throughout this report will not be achievable without accompanying cultural change.

Culture and leadership change needs to occur at all levels to drive the aim of this Review in strengthening multidisciplinary care teams to work to full scope of practice. Government and systems leadership, professional and organisational leadership, primary care services and health professionals, and consumers all have a role to play. An understanding that leadership occurs at many levels is needed to approach cultural change.

"Leadership must broadly encompass policymakers, professional organisations, consumers and individual practitioners. Where there are pockets of resistance to change, strategies to engage will be essential... The consumer should be central to the process, not professionals guarding their patch."

Consultation participant, health professional perspective

Australian, State and Territory governments should align in their commitment and leadership to progress the reform agenda. This will require a rise above traditional professional siloes to champion interprofessional collaboration, highlighting the role that all professions must play in meeting community need.

"[The] system that is firmly entrenched within the Australian culture will need to be fundamentally shifted with genuine recognition of the central role of the patient/consumer in health decision making and the importance of a far broader spectrum of specialised health care professionals who must be given the authority to work with the patients/consumers to drive efficient, timely and effective access to necessary services and support... The Government and all health professions must be committed to a cultural change as well as a systems change in Australian health.

Consultation participant, consumer perspective

Commitment to cultural change from a systems leadership level needs to be met with similar efforts within multidisciplinary care teams, to ensure they are working in a genuinely collaborative way. Professional silos and hierarchies need to be broken down for the intent of the Review to be progressed on the ground. While this shift needs to be demonstrated from systems leadership down, health organisations, professional bodies, care teams and individual professionals will be called upon to better commit to interdisciplinary understanding and trust. Primary care teams and services will need to be willing and supported to change how they operate and challenge some assumptions about who is, and is not, competent to deliver aspects of care.

"One of the greatest challenges to achieving the objectives of the proposed reforms is the current culture within, and across, the Australian health care professions. The lonstanding, and understandable, practice of individual professions advocating for the needs and wants of their own members has underpinned decades of interprofessional wariness. However, if the proposed reforms are to succeed, 'systems leadership' rather than advocacy is needed."

University of Melbourne, Faculty of Medicine, Dentistry and Health Science

Acknowledging the breadth of reforms called for, the upcoming National Health Reform Agreement (NHRA) negotiations represent a key opportunity to crystallise commitment from governments and all key stakeholders to the reform agenda. It is therefore recommended that all relevant recommendations should be incorporated into the upcoming NHRA by way of the agreement schedules which relate to health system reforms. This will be a critical action to drive collective momentum for the combined reforms put forward by this Review.

Recommendation 13

Governments and key stakeholders commit to and agree to progress the required reform program and governance structure to drive culture, leadership, implementation support and evaluation across the primary care system.

13.1 Australian, State and Territory governments agree to incorporate all relevant recommendations from this Review into the upcoming National Health Reform Agreement (NHRA), specifically into the respective schedules of the agreement which address agreed health system reforms.

D2. Primary care system integration and support through PHNs

PHNs are an enduring feature of the Australian primary care system and a key institutional mechanism to support and integrate primary care policy and programs across Australian, State and Territory government funded and operated health programs. They are also regionally based and governed with their geographical catchments aligning with State and Territory LHNs. The role of PHNs is also formally recognised in the NHRA. A recent Australian National Audit Office report provides a useful summary of the role of PHNs, as set out below: [151]

"Primary Health Networks (PHNs) were established by the Department of Health and Aged Care (Health) on 1 July 2015 as a delivery model for primary health care. There are 31 PHNs across all States and Territories in Australia. Each PHN is responsible for the ongoing assessment of health needs in the PHN region, supporting health services and stakeholders, and commissioning and integrating health services at the local level, to ensure that people can receive 'the right care, in the right place, at the right time'. PHNs have two key objectives:

Improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes

Improving the coordination of health services and increasing access and quality support for people.

PHNs work across seven priority health areas comprising mental health, Aboriginal and Torres Strait Islander health, population health, the health workforce, digital health, aged care, and alcohol and other drug services. PHNs contributed to seven programs in Health's 2022–23 Corporate Plan."

As noted throughout this report, PHNs are an important institutional actor and enabler of change in primary care at a local level. Throughout stakeholder consultations, the opportunity was highlighted for this role to be further strengthened, and potentially play a key enabling role in progressing a number of reforms proposed in this Review. Stakeholders also reported a degree of inconsistency in how PHNs manage primary care programs within their jurisdictions. Notwithstanding this view, PHNs have a longstanding role in supporting primary care and practices and operate across numerous program areas. Many have developed and commissioned innovative service models in areas of market failure, local services gaps and in support of national policy priorities.

This Review proposes that PHNs be supported and have capacity developed to enable them to contribute regionally and locally to implementation of the reforms. Capability uplift will be required to ensure support is delivered in a consistent way according to community need, and which is inclusive of all parts of the primary care system. Consideration of more inclusive decision-making processes and enhanced focus on the multidisciplinary team were frequently raised during consultation as areas for further development across PHNs.

"Primary Health Networks play a key leadership role at the local level in monitoring the health workforce. It is important that Primary Health Networks continue to build on their allied health engagement frameworks and to develop strong ties with dietitians and the wider allied health community."

Dietitians Australia

The proposed role for PHNs in the delivery of or support for specific reform proposals offers an opportunity for PHNs to strengthen their leadership of primary care in the above areas, and offer practical local support to practices, provider organisations, LHNs and health professionals in the implementation of the proposed reforms.

[151] Australian National Audit Office (2024) Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks. Accessed 1 August 2024.

Recommendation 14

The Australian Government develops a new capacity building and implementation support program for the 31 Primary Health Networks (PHNs) that will complement their existing planning, integration, practice support and commissioning functions in the primary care system. Specifically, these include:

A2 Strengthen the capability of the primary care workforce (Recommendation 2)

C1 Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice (Recommendations 10 and 11)

C2 Direct referral pathways supported by technology (Recommendation 12)

D1 Culture and leadership (Recommendation 13)

D2 Program governance, change management and evaluation (Recommendations 13 and 15)

D4 Clinical governance and risk management (Recommendation 17)

D5 Rural and remote focus (Recommendation 18)

D3. Program governance, change management and evaluation

Strong program governance is critical in the delivery of high-quality health care services that meet stakeholder expectations and assist in driving behaviour changes to enable continuous improvement. The essential elements in establishing and maintaining strong program governance are outlined below:

- **A set of core principles** to ensure that the purposes of the program and any proposed change within the system are well understood. Clinical governance and cultural safety would be among potential core principles to be agreed to underpin program governance.
- **The presence of strong leaders**, which acts as an enabler of significant reform to the primary care sector, to foster and continue to innovate. Strong leadership is defined as a mindset; rather than directing what people should do, it is about how to facilitate and enable adaptation, emergence, and change by activating people's agency.[152] Leadership in the primary care context should come from all key stakeholder groups including government and systems leadership, professional and organisational leadership, primary care services and health professionals, and consumers. Achieving HMM consensus and unified decision making on matters relating to primary care sets the tone for leadership, as outlined across various reform proposals.
- **Place-based tailoring of program governance** to local contexts includes the consideration of climate, leadership, and practice factors internal and external to the organisation. The importance of considering individual and place-based contexts is evident in rural and remote parts of Australia where, due to certain contextual factors such as scarcity, innovative health care models are frequently used to meet the health care needs of the community. Therefore, governance must adapt to the unique contexts in which it is established.
- **Recognition of external factors, complexity and high levels of interdependence** and connectivity between health systems is a further key consideration for program governance. Leaders should understand the characteristics most relevant to their own place-based context and tailor governance structures accordingly. The importance of co-design in this process is highlighted.[153]
- **An agreed mechanism to drive reform,** in this case recommended to occur through incorporating review recommendations into the upcoming NHRA (see Recommendation 13.1).

Stakeholders also recognised the importance of inclusive program governance structures, where the voices of various professions, and of consumers, are equally heard and valued. This diversity in representation ensures decision-making is comprehensive, holistic and considers the perspectives, knowledge and experience of all stakeholders involved across the primary care journey.

"...there must not be a formal hierarchy within these teams... Let's make them truly equal, flexible and agile in the way they operate."

Consultation participant, peak organisation perspective

Significant and ongoing engagement across all parts of the primary care sector will be required to clearly communicate the intent and substance of reforms and support change management. This needs to be underpinned by an understanding and communication about the value that all primary care professionals bring in meeting community need. It needs to consistently reinforce the multidisciplinary care team as the optimal mode of delivering primary care, especially for those with complex conditions and/or multimorbidity and the need to break down professional siloes and hierarchies in working together.

"It will be important to deliver consistent communications and information [to] the health sector, and the various professions within the sector...The role of health professionals in the communication of changes to patients, colleagues and other stakeholders will also be critical."

Consultation participant, regulator perspective

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[152] Hilton K, Anderson A (2018) IHI Psychology of Change Framework to Advance and Sustain Improvement. Boston, Massachusetts: Institute for Healthcare Improvement.

[153] Damschroder LJ, Aron DC, Keith RE, Kirsch SR, Alexander JA, Lowery JC. (2009) Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Science. 4:50. https://doi.org/10.1186/1748-5908-4-50

A consultative approach should apply to the design and implementation of all reform proposals detailed throughout this report, as well as to change management efforts. From consultation, there was a clearly identified need for continuous consumer involvement in design and implementation across reform options, ensuring community needs and lived experience are kept at the centre of reform. The need was also emphasised for greater inclusivity across primary care professionals – addressing a traditional underrepresentation of some areas of the primary care workforce such as allied health and self-regulated professions.

"There needs to be true representation from the allied health sector in future workshops, committees, taskforces and reference groups. Cooperation cannot exist if not all parties are represented and engaged in the conversation."

Australian Orthotic Prosthetic Association

"Lived experience needs to have a strong voice on the ground. They are receiving the care and they know exactly what is and what is not working."

Consultation participant, consumer perspective

Shifting the primary care system towards coordinated multidisciplinary teams of health care professions, who can work to their full scope of practice, represents a significant piece of change requiring an underpinning change management model.

The **Institute of Healthcare Improvement "Psychology of Change Framework"** [154] is a strategic approach to fostering and maintaining improvements in health care settings. The framework centres on the psychological and emotional aspects of change and emphasises the importance of engaging individuals and teams across all levels of the system to ensure change efforts are both inclusive and effective.

The framework comprises of the following 5 interrelated domains of practice that organisations can use to advance and sustain improvement.

1. **Unleash intrinsic motivation** refers to tapping into sources of intrinsic motivation to encourage people's individual and collective commitment to act.
2. **Co-design people-drive change** involves working collaboratively with patients, families and health care providers to design programs. Through the inclusion of diverse perspectives, co-design helps to ensure changes are relevant and applicable to all stakeholders.
3. **Co-produce in authentic relationship** focuses on actively involving those affected in change in the creation and implementation of solutions.
4. **Distribute power** advocates for shared leadership responsibilities across all levels of the organisation. Empowering frontline staff to take ownership of change management activities ensures key stakeholders are encouraged to take responsibility of the change journey.
5. **Adapt in action** recognises that change is dynamic and often unpredictable, which requires individuals, teams and systems to learn and iteratively adjust their approaches and strategies in order to be effective.

The Australian Government should consider building a change management model unique to Australia, based on the framework, to demonstrate leadership and underpin the proposed significant reforms in the Australian primary care sector.

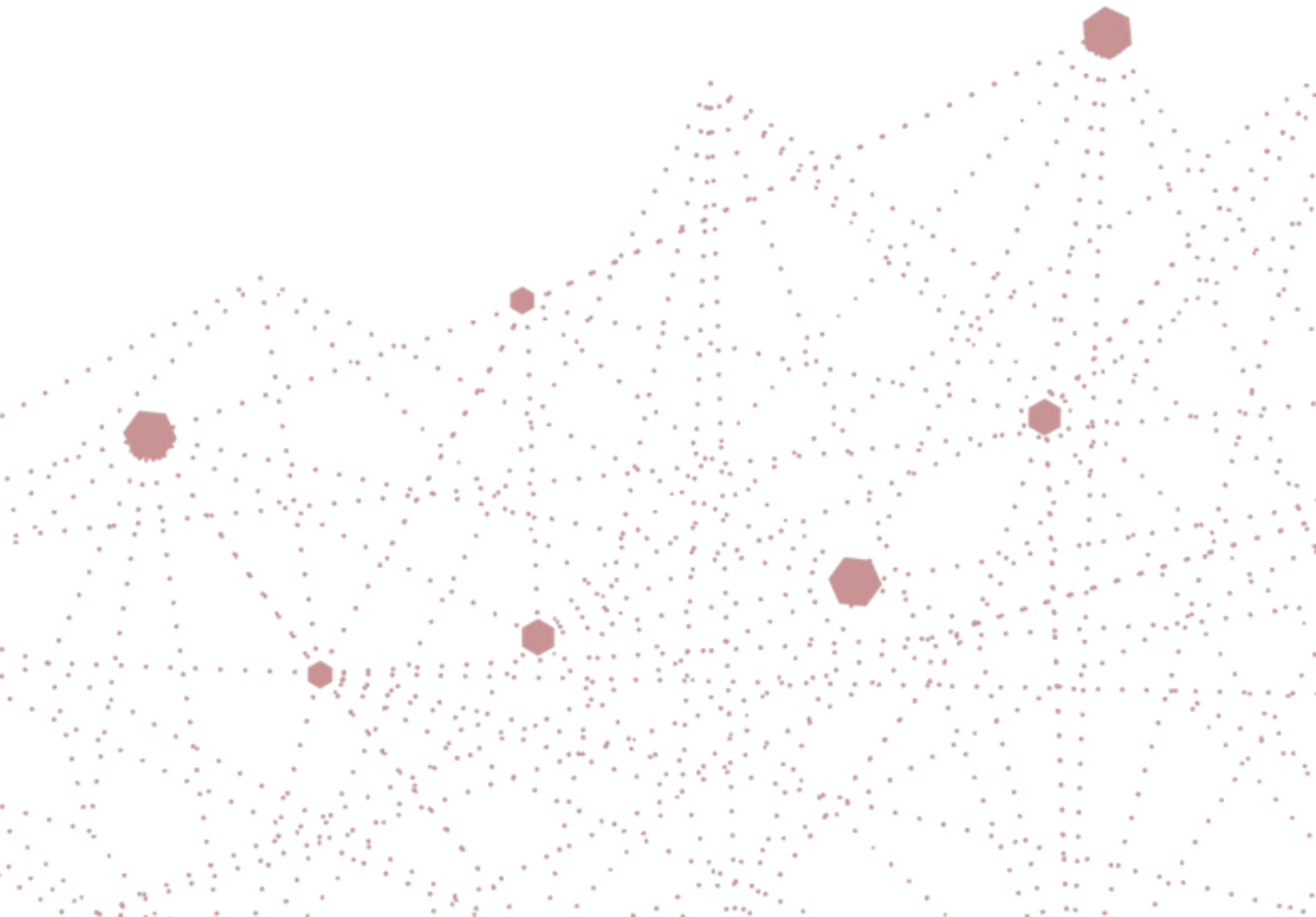
[154] Hilton K, Anderson A (2018) IHI Psychology of Change Framework to Advance and Sustain Improvement. Boston, Massachusetts: Institute for Healthcare Improvement.

Each newly established program will require ongoing monitoring and assessment of their effectiveness and impact to ensure they are meeting intended objectives and are contributing to overall health outcomes of populations. Evaluation strategies will need to accompany these programs to provide a systematic method to understanding their impact of health interventions and identifying areas for improvement.

Recommendation 15

Governments, working with relevant professional associations, develop and implement communications and training strategies about the intent and substance of reforms to strengthen multidisciplinary primary care teams working to full scope of practice.

15.1 Embed a consumer co-design and consultation element in design and implementation phases associated with all recommendations.



D4. Cultural safety

Cultural safety is a critical element of culture and leadership requiring specific and ongoing attention across the primary care workforce, to ensure First Nations health professionals are enabled to work to their full scope of practice and for First Nations community needs to be addressed. Consultation participants emphasised that while Aboriginal and Torres Strait Islander Health Practitioners and Health Workers and other First Nations health professionals have particular expertise in cultural safety, cultural safety is a shared responsibility of everyone to uphold. Furthermore, significant and ongoing problems with mainstream recognition and respect for Aboriginal and Torres Strait Islander Health Professionals was called out, attributed to racism and a lack of interprofessional understanding.

Significant work has been completed to develop a shared definition of cultural safety across the National Registration and Accreditation Scheme. The development of this shared definition was led by the Aboriginal and Torres Strait Islander Health Strategy Group as part of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.[155] It is a critical step towards achieving the strategy group's principles of eliminating racism against First Nations peoples in health care, moving towards a rights-based approach to health care, and demonstrating ongoing commitment to learning. As a shared definition across NRAS, this definition is well-understood across primary care professions, although not formally shared amongst professions not regulated under NRAS.

Definition of cultural safety for the National Scheme[156]

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care, free of racism.

To ensure culturally safe and respectful practice, health practitioners must:

- Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
- Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, and free of bias and racism
- Recognise the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community
- Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.

According to this definition, it is vital for multidisciplinary health care teams to be inclusive of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and other First Nations health professionals. This means health professionals must have the capacity and capability to work alongside each other and value the role Aboriginal and Torres Strait Islander Health Practitioners and Health Workers and other First Nations health professionals play in providing culturally safe care to First Nations peoples, families and communities.

[155] Ahpra & National Boards (2023) Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Accessed 1 September 2024.
[156] Ahpra & National Boards (2023) Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Accessed 1 September 2024

Equally, it is vital that multidisciplinary care team members learn from and listen to their First Nations colleagues in the delivery of culturally safe primary care. In many cases, this will involve challenging assumptions about how primary care has traditionally been delivered, and recognising and responding to attitudes and behaviours that perpetuate racism and power imbalances in primary care settings.

"[What is required is] To encourage … to communicate and listen to feedback."

Consultation participant, First Nations health professional perspective

Strong examples of multidisciplinary care teams operating in the ACCHO model were illuminated throughout this Review. The blended funding model which applies in these settings was a clear enabler and exemplar for the primary care sector in applying flexible funding to deliver multidisciplinary team-based care according to community needs. Specific exemplars deliver a holistic model of care through multidisciplinary care teams which feature equalised roles across professions.

In addition to the funding mechanism, the community-controlled governance mechanism was emphasised by First Nations stakeholders as also having a substantial impact on the delivery of the ACCHO model. Because of this, stakeholders warned against assumptions that outcomes seen in the ACCHO model could necessarily be achieved if the model was 'scaled up' to mainstream services with different governance structures. In learning from First Nations-led models of care, it is important to acknowledge and value the First Nations peoples who originally pioneered these models, and the impact they have had for the entire primary care system.

A meaningful and ongoing emphasis on cultural safety across all primary care contexts is critical in attempting to learn from the successes of the ACCHO model. Cultural safety is understood to be a shared responsibility requiring dedicated and ongoing learning throughout the career span. Therefore, while it should be reflected as being shared across all primary care professions (such as in *Section A1*), care must be taken to avoid the implication of cultural safety as 'tick box' or one-off, and a continuous learning culture must be fostered.

"Cultural Safety must be at the forefront of our goal of closing the gap… everyone must be given an opportunity to enhance their education and skill set. Employ people who will make it happen [and] ensure community-controlled health services support their staff."

Consultation participant, First Nations health professional perspective

The role First Nations communities play as a ground for innovation and research was also highlighted. However, consultations raised that this innovation often goes unrecognised on a broader scale. In the context of a highly stretched workforce and over-researched communities, community impact needs to be at the forefront of any action in this area. Investment in First Nations-led research to generate evidence about what works in primary care is critical to highlight and accelerate the work already being done, including at a grassroots level. Stronger avenues for bringing this evidence to light, and implementing into broader practice, was also highlighted as a need (such as through an independent mechanism to assess evidence in emerging workforce models and significant scope change).

The recommendations to progress work to commit to a shared definition of cultural safety across the primary care system intersect with other recommendations in this report, namely the development of a professional capabilities framework for First Nations health care in accreditation standards and associated continuous professional development (see *Section A2*). These professional capabilities seek to support consistent, cross-professional education and learning relating to cultural safety across professions.

Recommendation 16

The Health Ministers' Meeting (HMM) agree to progress work in partnership with First Nations stakeholders to commit to a shared definition of cultural safety across primary care, based on the definition of cultural safety for the National Registration and Accreditation Scheme (NRAS).

16.1 The Health Ministers' Meeting (HMM) agree to incorporate cultural safety as a foundational shared capability in the first iteration of the National Skills and Capability Framework and Matrix (Recommendation 1).

D5. Clinical governance and risk management

Robust clinical governance mechanisms are fundamentally important to health care safety and excellence, including in the primary care system. As in other areas of health care, primary care clinical governance requires individual health professionals and provider organisations to have structured mechanisms, policies and governance systems in place to understand and comply with expected standards of practice (governance, leadership and culture), undertake structured activities to reflect and review their individual and collective practice, accountabilities and related risk (patient safety and quality systems, clinical performance and effectiveness), commit to consumer-centred care (Partnering with Consumers standard), [157] and understand and respect own and other team members' scopes of practice and contributions to team care (safe environment for the delivery of care). [158, 159] However, clinical governance mechanisms and related supports in the primary care sector are typically dispersed and distributed across practices, providers, teams and individual health professions to a greater extent than other parts of the health system. This reflects the historical, disaggregated business structure of the primary care sector.

In contrast, hospital settings have stronger, more robust, better resourced institutional support and infrastructure for clinical governance and risk management. This is accompanied by mandatory, enforceable standards overseen by the ACSQHC, and co-regulated with the State and Territory Governments. Ongoing accreditation against national standards is mandatory for providers of hospital services. Though primary care clinical governance should involve similar embedded structural quality and safety assurance mechanisms, there is diversity in how this looks in practice across settings.

In the context of reforms which potentially change the activities that primary care providers and health professionals are authorised to do, a robust, nationally consistent clinical governance environment is of heightened importance. For example, if multidisciplinary care teams are supported through these reform options to enable all professions to work to full scope of practice, there will need to be commensurate and proportionate efforts to support cohesive clinical governance.

"Knowledge and understanding of clinical governance is quite varied in the primary care sector, particularly in smaller, private practices where there may be more focus on clinical autonomy... A reasonable level of protection needs to be offered at a national or state regulatory level because of the varied capacity of smaller organisations to establish, manage and sustain appropriate local clinical governance."

Consultation participant, First Nations health, rural and remote health professional perspective

Clinical governance and quality assurance are integral to all reform proposals outlined throughout this report, as critical enablers of proactive risk management where health professionals are working to full scope of practice.

Consultation feedback indicates there is widespread desire for a strengthened and more consistent clinical governance mechanism in the primary care system, particularly to support the specific reforms proposed through this Review.

Accreditation processes ensure health services comply with safety and quality standards and have quality improvement strategies in place to promote safe and high-quality healthcare. [160]

[157] ACSQHC (Australian Commission on Quality and Safety in Health Care) (n.d.) Partnering with Consumers Standard. Accessed 1 August 2024.
[158] ACSQHC (Australian Commission on Quality and Safety in Health Care) (2021) National Safety and Quality Health Service Standards (second edition). Accessed 1 August 2024.
[159] ACSQHC (Australian Commission on Quality and Safety in Health Care) (2021) National Safety and Quality Primary and Community Healthcare Standards. Accessed 1 August 2024.
[160] ACSQHC (Australian Commission on Quality and Safety in Health Care) (n.d.) Consumers and accreditation. Accessed 1 October 2024.

The ACSQHC is responsible for administering the National General Practice Accreditation (NGPA) scheme [161], developed with the Royal Australian College of General Practitioners and based on their standards for general practice and point of care testing. The scheme in its current form commenced in 2017. In 2021, ACSQHC also released NSQPCHS [162] for the primary care system. Both NGPA and NSQPCHS include specific governance standards.

While both sets of standards are robust, national, mature, and have an architecture consistent with other ACSQHC standards, accreditation of practices and provider organisations against them remains voluntary. As a result, there is less visibility over the consistency with which these standards are applied in primary care practice. Unlike accreditation in the hospital sector, statutory mechanisms to independently assess and enforce compliance with the NGPA scheme and the NSQPCHS are absent.

Although there are inherent challenges in implementing a single model of clinical governance across a dispersed primary care system, the current lack of mandated clinical governance mechanisms also carries risks. It is likely to perpetuate lack of clarity or professional bias about what activities can safely be carried out by whom, since decisions may not be made according to the same guiding principles across settings.

Based on the above considerations, this Review recommends a two-pronged approach to strengthening clinical governance as a key enabler of the reforms proposed in this report. It should be noted that this is already required of ACCHOs receiving Indigenous Australians' Health Programme funding from the Australian Government, but is not required of mainstream primary care providers funded through MBS or other existing practice related payments. Firstly, it is recommended that practices (as defined previously, see *Section C1*) should be mandated to participate in the relevant ACSQHC accreditation scheme. Secondly, a program of support for this change should be developed and implemented to enable all primary care providers to successfully participate in the mandatory accreditation schemes.

PHNs are one institutional mechanism which could be tasked with a new function to commission or directly provide support for primary care providers to strengthen their approach to clinical governance and risk management activities.

Capability uplift will be required to enhance the proposed clinical governance support role of PHNs, noting evidence that there is inconsistency in how PHNs currently engage with local primary care systems and providers, particularly allied health.[42] It is important to note that the proposed program of support is not confined to assisting with a transition to mandatory accreditation. It should have an ongoing role in capacity building for clinical governance and quality assurance across the primary care sector.

A final, but important, issue is the consideration of the potential impacts on professional indemnity insurance (PII) of a changing risk profile due to more health professionals working to a full scope of practice. All NRAS-regulated health professionals are required to be covered by PII for the health care they provide and most self-regulated health professionals in private practice also hold PII. As a general rule, in the primary care sector, many employed health professionals (other than doctors) are covered by their organisation's PII arrangements and many also take out additional personal PII. However, GPs working in private practice are generally not covered by their organisation's PII arrangements, and are required to obtain their own individual PII, irrespective of the way they are engaged.

In general practice, where most primary care services are delivered by GPs, nursing and some allied health professionals, the practical impact is that the combined liability of the team tends to be covered by the individual GP or practice level PII arrangements. This reflects the longstanding professional accountability for the team resting with the GP or practice and is reflected in the historical claims patterns of PII providers.

This longstanding PII arrangement and claims profile may potentially be disrupted by a significant sector wide shift in the proportion of health professionals working to full scope of practice in multidisciplinary teams in the primary care sector. In multidisciplinary teams, it is critical to have a clear understanding of each member's responsibilities, their accountabilities and who will provide indemnity, whether for each team member or the practice in which they work, particularly if they are independent contractors. This clarity will allow all health care professionals to understand how and where they will be indemnified.

[161] ACSQHC (Australian Commission on Quality and Safety in Health Care) The National General Practice Accreditation Scheme. Accessed 1 August 2024.
[162] ACSQHC (Australian Commission on Quality and Safety in Health Care) (2021) National Safety and Quality Primary and Community Healthcare Standards. Accessed 1 August 2024.

While the literature considered in this Review suggests this disruption is unlikely, there are limitations in the ability to identify what impact, if any, this change is likely to have on future PII claims patterns. It will be important to work with PII providers to monitor and assess any impacts. The learnings gained from the experience of PII providers should be used by governments to inform clinical governance and risk management mechanisms in a manner proportionate to changing risk. The following recommendations are intended to support these efforts.

Recommendation 17

The Australian Government mandates participation by all primary care providers in an accreditation program under the applicable Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation schemes, or other relevant accreditation programs, i.e.:

- National Safety and Quality Primary and Community Healthcare Standards, or
- National General Practice Accreditation
- Quality Care Pharmacy Program.

17.1 The Australian Government implements a program of capacity building for clinical governance, risk management and quality assurance across the primary care sector to be supported by Primary Health Networks (PHNs) or other appropriate bodies.

D6. Rural and remote focus

Multidisciplinary team-based care provided by health professionals working to full scope of practice is a common feature of primary care in rural and remote regions. Extensive evidence was provided from health professionals working in rural and remote regions that the expectation amongst colleagues is a collaborative and multidisciplinary model of care.
Health professionals working in rural or remote areas report stronger interprofessional understanding and trust among colleagues, are more likely to refer to team members according to their scope of practice and communicate more regularly about care provided within their community.

“Nowhere is the safe maximisation of scope of practice more critical than in Australia's very remote communities.”

Consultation participant, rural and remote health professional perspective

“The best thing about the country is the people, where you live you’ll get providers working together – but it’s often the funding stopping the solution from working.”

Consultation participant, rural and remote peak organisation perspective

However, notwithstanding these positive aspects, regional and remote primary care teams are subject to similar scope of practice barriers as the broader primary care workforce, and their effects on communities tend to be exacerbated. Rural and remote regions are subject to more significant workforce shortages and are therefore more heavily impacted by scope of practice issues. In addition, while there are some similarities in terms of the overall complexity of community need across rural and remote Australia, local need will be specific to each community, with implications for what scope of practice is required of the local workforce.

“It is essential to recognise that primary health care delivery in rural, remote, and isolated areas is very different from urban areas in context and resourcing… Such contexts require significantly different clinical and professional skills.”

CRANAplus

Numerous examples were provided where scope of practice barriers in rural and remote areas entirely prevented community members from accessing the care they need when they need it. Many of these issues revolve around the lack of consistent presence of medical staff in rural and remote areas, meaning that activities requiring the input or authorisation of a GP are prevented from consistently taking place. This Review acknowledges the critical importance of continued efforts to increase the numbers and coverage of the GP and broader primary care workforces in rural and remote areas. However, consumers and health professionals representing rural and remote regions strongly advocated for additional reforms to remove barriers to the existing primary care workforce working to their full scope of practice, especially in areas where GPs and the traditional model of general practice are not available or viable.

Insights from consultation

A Victorian example was raised where pharmacists working in regional Medicare Urgent Care Centres are prevented from supplying medicines unless there is a medical practitioner on the premises, despite most weekend and after-hours urgent care being provided by nurses in this setting. Consumers are therefore prevented from being supplied medicines when medical practitioners are not present, despite having access to health professionals with the necessary skills, qualifications and competence to deliver this service.

Because local rural and remote primary care teams tend to operate in an environment of scarce workforce availability, they were frequently identified as sites of scope of practice innovation. Innovative primary care workforce models (such as the use of community paramedics to deliver care into the community) are more readily accelerated in rural and remote areas because of the everyday requirement to reimagine primary care delivery in order to meet community needs. Education and training provided in rural and remote primary care tends to provide students with a broad, generalist experience, which is highly valued. However, supervising training in these areas requires additional support, with available supervisors experiencing challenges relating to the persistent need to contribute to training in addition to performing regular duties. Refer also *Section* A2.

Health professionals in rural and remote regions may face additional barriers in seeking to work to their full scope of practice. Undertaking additional advanced practice training typically involves more significant travel expenses as well as locum cover expenses to the employer and can act as a disincentive to pursuing additional education, requiring targeted efforts to overcome.

"There is already an underspend. We need to acknowledge the economic benefits that our rural communities bring to Australia. There are also other benefits to organising [rural and remote] placements, such as exposing more people to rural communities and life, making trainees and students feel like they are part of a team."

Consultation participant, rural and remote perspective

In summary, rural and remote regions present the greatest immediate opportunity to establish and spread health workforce innovation and reform. They simultaneously demonstrate the most significant adverse impacts of its absence, have more incentive to embrace it and display more of the essential cultural and leadership characteristics for it to advance. Therefore, targeted efforts to the design and implementation of most recommendations put forward by this Review will be critical to ensure rural and remote communities experience the full benefit of the combined reforms.

Recommendation 18

Governments commit to prioritise implementation of reforms in rural, remote and underserviced areas, and to engage with relevant organisations and stakeholders to collaboratively design implementation solutions specific to rural, remote and underserviced communities, commencing with:

A2 Strengthen the capability of the primary care workforce – design specific implementation pathways for a primary care workforce development program (Recommendation 2), including specific support mechanisms to enable students to travel and stay in rural and remote locations while completing education and training/placement.

B2 Independent, evidence-based support for health workforce innovation, access and productivity – commence the innovation assessment process with rural and remote workforce models (Recommendation 9).

C1 Funding and payment models enable and support health professionals in multidisciplinary care teams to work to full scope of practice, through introduction of a new blended payment and a transition payment (see Recommendation 10) which:

- Makes appropriate and equitable adjustments at the fundholder level for historical underutilisation of MBS and other primary care programs due to long-standing GP, nursing and allied health shortages (Recommendation 10.4)
- Incentivises establishment and spread of innovative multidisciplinary models of care including rural generalists, nurse/allied health/midwifery led clinics, and advanced remote service delivery models (Recommendation 10.4).
- Design and implement an alternative patient registration model to ensure access to the broad-based risk adjusted blended payment for historically underserviced communities, prioritising rural and remote areas (Recommendation 10.6)
- Implement the blended payment model in a staged program commencing with rural and remote regions (MMM 5-7) and underserviced regional areas (Recommendation 10.8)
- Implement the bundled payment for maternity care with a targeted rural and regional model (Recommendation 11)

C2 Direct referral pathways – commence implementation in rural and remote regions (Recommendation 12).

D2 Primary care system integration and support through Primary Health Networks (PHNs) – focus capability uplift in rural and remote PHNs to support the above targeted implementation efforts (Recommendation 14).

D7. Digital health

Robust digital health systems are crucial for underpinning the effective functioning of the primary care system. Recent and ongoing investment through the National Digital Health Strategy seeks to strengthen these systems, in recognition of the need for enhanced sharing of health information between health professionals.

"For [multidisciplinary care] teams to be effective and independent, the right digital health technology is essential. Such technology enables the sharing and reviewing of medical records, facilitates case conferences, and ensures high-quality care."

Australian Physiotherapy Association

Digital health systems are particularly critical as an enabler of multidisciplinary team-based care. Safe and secure messaging and event notification tools allow for communications across the health care team, as the consumer accesses different services at different times and from different locations according to their needs.

In the absence of these tools, health professionals describe being prevented from meaningfully engaging in a consumer's ongoing care. In the current state, My Health Record access and upload rights are not available to all health professions, and many in the primary care system are unable to access the information they need in a timely manner at all.

Insights from consultation

Many health professionals working in the primary care system, particularly those representing allied health professions, observed the impact that lack of integration into existing digital systems has on their ability to engage fully in multidisciplinary team-based care.

"We note that at present, there is no consistent two-way electronic service for psychologists and GPs to communicate with each other (e.g. for psychologists to receive referrals from GPs and for psychologists to provide their required reports back to the GP). One popular commercial system is free for GPs to use, but a subscription fee is required for allied health providers to send messages to GPs. The uneven playing field reflects the lack of government investment in digital technologies for allied health providers working in primary care."

Australian Psychological Society

"Updates to digital infrastructure and My Health Record to improve multidisciplinary communication… are integral to support professional communication and timely referral."

Australian Orthotic Prosthetic Association

"Podiatrists are private practice in Australia by and large. This leads to complications with digital interoperability - we have little to none, view-only My Health Record access, and no secure messaging. How do we work with others in the care team - fax?"

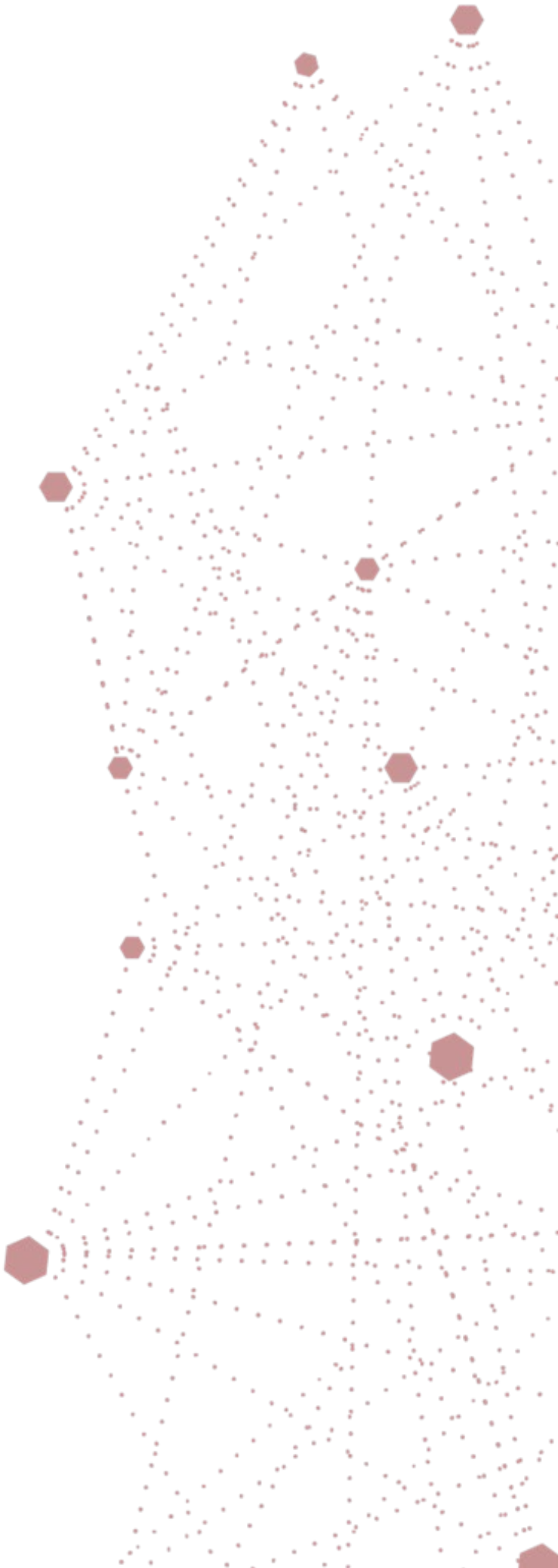
Consultation participant, rural and remote perspective

The ongoing implementation of the National Digital Health Strategy is expected to support the overall intent of this Review, with a focus on improving digital communications between health professionals via enhancements to National Digital Health infrastructure. This should also be supported by efforts to enhance My Health Record access for all primary care professions.

Innovations in digital health continue to influence how primary care is delivered and received, with telehealth continuing to be an important aspect of the health system, particularly in rural and remote regions. Remote supervision and mentoring are also enabled by similar technologies and will continue to support the flexibility of the workforce in meeting the needs of both communities and emerging health professionals.

A number of reform proposals identified within this report have a requirement of a digital environment to support their effective implementation. For instance, digital infrastructure to support multidisciplinary health teams (secure messaging, instant event notifications, results reporting) are an assumed condition of blended funding models. Similarly, use of digital notifications (including those to be implemented as part of developing National Health Information Exchange capabilities) are identified as a core expectation of revised direct referral pathways.

A digital interface will enhance the accessibility and influence of other reform proposals, such as sector and consumer-facing versions of the Skills and Capability Framework and Matrix (Recommendation 1), and consideration of remote forms of supervision and mentoring. Finally, digital health is expected to continue to be an area of innovation and change in primary care, and it is important the system remain adaptive to these models where they are proven to be effective. The proposed independent mechanism for assessment of innovative health workforce models and the resulting flow through to legislative, regulatory, and funding reforms will be strengthened and enabled by a robust, modern and adaptive digital health foundation.



D8. The business model of primary care and general practice

This section discusses aspects of the business model of primary care, general practice and the health professionals that operate within it. For the purpose of this discussion, 'general practice' refers to the service delivery entity and its organisational arrangements. 'General Practitioner (GP)' refers to the specialist medical practitioner. 'Primary care' is a term which encompasses the model of care, service delivery points, and range of health professionals who contribute to that model. Definitions for each can be found in the *Glossary*. There are many intersection points across these terms, and they are commonly used interchangeably by a range of stakeholders, consumers and the community more broadly.

General practice is the main context and service delivery model for most primary care services in Australia. ACCHOs, nursing, midwifery and allied health practices, State and Territory government-operated health services, community pharmacies and private dental services. are also important primary care service delivery models.

However, considering the depth, breadth, volume and comprehensiveness of primary care services offered under the one roof, general practice and ACCHOs are the predominant business models of primary care. For consumers general practice and ACCHOs are typically their first and ongoing delivery point for continuous, comprehensive and co-ordinated primary care. General practice and ACCHOs, along with PHNs, are also the principal institutional mechanisms for Australian government funding and payments for primary care.

The latest full year data recorded approximately 197 million MBS funded primary care services in Australia in 2022-23, as shown in the breakdown in Table 5.[163] Of note is that 84% of these services were provided directly by a GP. Much of the balance of MBS funded services, whilst provided by other health professionals, are pursuant to an assessment, referral or other action by a GP, e.g. Chronic Disease Management items.

Table 5 MBS funded primary care services 2022-23

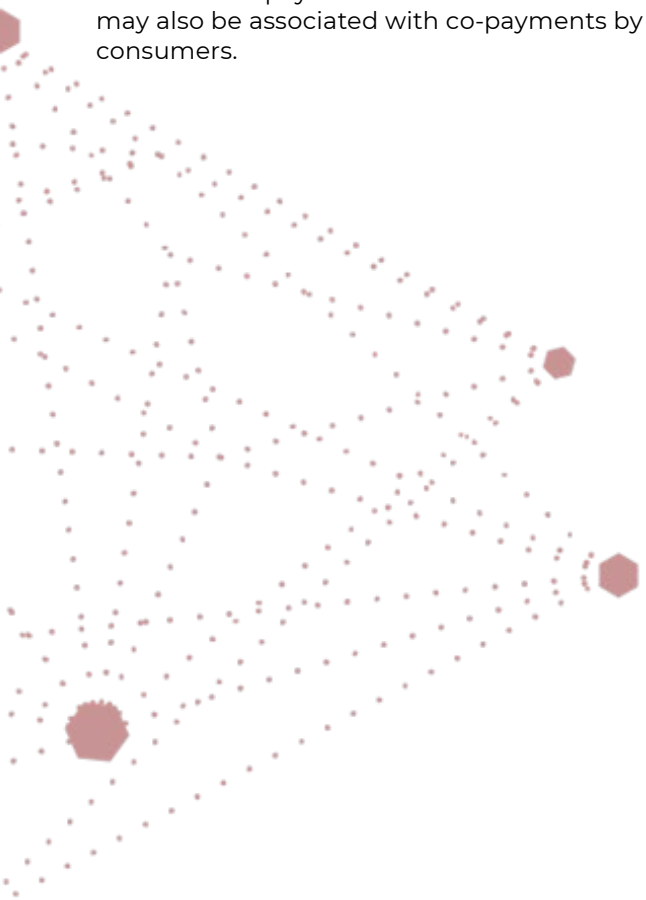
Health professional provider	MBS services (million)	Proportion of total services by provider type (%)	Proportion of people who received a service in the year (%)	Rate (per 100 people) of service provision in the year (2022-23)	MBS benefits paid ($ billion)
GP	166	84	86	639.2	8.7
Allied Health	27	14	39	102.1	1.8
Nursing & Aboriginal & Torres Strait Islander Health Workers	4.3	2	8	16.4	0.1
TOTAL	197.3	100			10.6

[163] Australian Institute of Health and Welfare (2024) General practice, allied health and other primary care services. Accessed 20 September 2024.

In addition to this, the Australian Government provides funding to support general practice through a range of initiatives and programs. In 2022/23, the Australian Government outlaid a further $2.84 billion (b)[164] comprising:

- $1.89 b for PHN commissioned services
- $0.43 b for Practice Incentive Payments (PIP)
- $0.52 b for ACCHOs.

PHI is also a significant funding source and payment type for non-medical primary care service delivery, contributing $6 b in 2022-23. This comprises benefits paid for dental ($3.3 b) and the balance ($2.7 b) a mix of allied health, ambulance and other services. The Australian Government, through its PHI rebate, contributes to this important funding stream by up to 32% of the PHI policy premium paid by policy holders, depending on their age, income and type of policy. MBS and PHI payments and services described above may also be associated with co-payments by consumers.



From the above summaries of Australian Government policy and program investment in primary care the following observations can be made:

1. General practice and ACCHOs, by scale and volume, are the main delivery vehicle for the Australian Government's commitment to universal, comprehensive primary care services.
2. Community pharmacy is the national delivery point for access to essential medicines and related professional services – a key element of the primary care system.
3. PHI supports access to non-medical primary care services for those consumers who hold general PHI policies, but it is not universal.
4. The vast majority of the service delivery under the above programs is:
    a) Provided by private sector or non-government entities, and
    b) Paid for through fee-for-service arrangements.
5. State and Territory governments also play an important role in the primary care sector, particularly in rural, remote, underserviced and specialised areas. Through the NRHA, the Australian Government funds the States and Territories a portion of the cost of these services which are provided universally and typically with no or minimal consumer co-payments.

The centrality of general practice to primary care, and the critical role played by GPs within it, are longstanding, bipartisan policy features of the Australian health system. This is most recently reflected in two Australian Government policy statements i.e. *Strengthening Medicare*[165] and *Australia's Primary Health Care 10-year Plan*.[166] Throughout the course of this Review the RACGP and the AMA – the two largest national professional bodies representing GPs – have strongly advocated for recognition of the critical role of GPs in primary care and in implementing the current program of policy reforms. Both organisations have been key advocates in the *Strengthening Medicare* reforms and active in ensuring that their members are engaged, prepared and supported for the changes ahead. This Review recognises both the critical role played by general practice and GPs in the primary care sector (see above) and the need for support and engagement in design and implementation of whichever reforms are ultimately agreed to.

[164] Department of Health & Aged Care (2024). Primary care program summary payments - 2022/23 (internal, unpublished report supplied to the Independent Review Lead)
[165] Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.
[166] Australian Government Department of Health and Aged Care (2022) Australia's Primary Health Care 10 Year Plan 2022–2032. Accessed 1 September 2024.

This also applies to other stakeholders and is addressed in this section (see Recommendations 13, 14, 15 and 17).

Specific to this Review and its focus on barriers to working to full scope of practice in multidisciplinary teams, the RACGP points to some examples of scope of practice restrictions faced by GPs, that are unrelated to their skills, qualifications or competence. These include PBS rules that restrict GPs prescribing for conditions such as attention deficit hyperactivity disorder (ADHD), dementia, acne, human immunodeficiency virus (HIV), anaphylaxis and selected cancers; and MBS rules that restrict ordering MRIs, undertaking electrocardiograms (ECGs) and delegating a range of clinical activities to other health professionals within the multidisciplinary teams. This Review makes a series of system-focused recommendations in *Theme B: Legislation and regulation*, and *Theme C: Funding and payment policy* that enable potentially unnecessary restrictions on scope, such as those raised by the RACGP to be considered through new, ongoing, evidence-based institutional mechanisms.

Key elements of *Strengthening Medicare* are increasing access to multidisciplinary care, patient registration at a nominated practice and significant changes to long-standing fee-for-service payment models to support access to better co-ordinated and planned care, delivered by multidisciplinary teams working to their full scope of practice. A critical enabler of any recommendation from this Review (and other *Strengthening Medicare* reforms) is the readiness and capacity of the underlying business and industry structure of general practice to adopt and deliver the significant program reforms proposed.

The historical general practice model in Australia was that of GP-owned solo or partnership group practices of relatively small scale.[167] This changed significantly in the mid-1980s, with corporate entities establishing groups of practices, declining numbers of solo practices and increased size of non-corporate group practices. Sourcing good quality, reliable data series on the size and structure of the general practice sector is not straightforward, but a recent study [168] and a 2024 survey series [169] enable the following observations:

- Around 45% of GPs work in a practice which is a private company
- 20% of GPs worked for a corporate group practice and 69% for a non-corporate group practice during the last month
- 25% of GPs identify as practice owners, and only 10% of non-owner GPs aspire to own a practice (down from 25% six years prior)
- The main sources of revenue for GPs are fee-for-service payments, which comprise around 95% of revenue for GPs working in corporate group practices, and over 90% for GPs working in non-corporate group practices.

[167] Scott A, Taylor T, Russell G, Sutton M. (2024) Associations between corporate ownership of primary care providers and doctor wellbeing, workload, access, organizational efficiency, and service quality. Health Policy. 142:105028. https://doi.org/10.1016/j.healthpol.2024.105028
[168] Ibid.
[169] Royal Australian College of General Practitioners (2024) General Practice Health of the Nation: An annual insight into the state of Australian general practice. Accessed 1 September 2024.

Against this backdrop, there are some significant issues and growing pressure on the current business model for general practice and these are well summarised in the latest RACGP *Health of the Nation 2024*.[170] The top three challenges reported by GPs are being undervalued as a GP, understanding and adhering to regulatory and policy challenges, and managing workload. Other key findings in this report include:

- 81% of GP owners are concerned about the viability of their practice, rising from 54% in the four years prior. The top three business challenges identified by survey respondents are increasing business costs (85%), profitability (80%) and sourcing and retaining GPs (77%).
- Differences in job satisfaction exist, with 88% of GPs working in ACCHOs and 78% of those working in hospitals reporting being highly or moderately satisfied, compared with 73% of those working in non-corporate group practices and 72% in corporate group practices.
- Recent health workforce supply and demand projections released by the Department of Health and Aged Care[171] highlighted other challenges facing general practice and primary care.
- A shortfall in the number of GPs (from a baseline/status quo projection where current supply is assumed to meet demand i.e. equilibrium) of over 800 in 2024, increasing to over 2,600 by 2028, and 8,600 GPs by 2048.
- The unmet demand projections (which does not assume an initial equilibrium) estimate a current shortfall of over 2,400 FTE in 2024, increasing to around 3,900 FTE in 2028, and to over 8,900 FTE by 2048.
- In terms of reliance on overseas trained medical practitioners, the projected proportion of the GP workforce who are Australian/New Zealand Medical Graduates (AMG/NZMG) is expected to decrease from 53.3% in 2023 to 47.6% by 2048. The projected proportion of the total FTE provided by GPs who are AMG/NZMGs is expected to decrease from 42.8% in 2023 to 39.4% in 2048.

The relevance of the above to this Review is that the strength, capacity, and fitness-for-purpose of the underlying general practice business model, which accounts for the vast majority of primary care service delivery, will be a critical enabler of successful implementation of reforms proposed in this Review. Other recommendations included elsewhere in this section (Recommendations 13, 14, 15 and 17) are intended to support change management and build capacity.

[170] Ibid.
[171] Australian Government Department of Health and Aged Care (2024) Supply and Demand Study General Practitioners in Australia. Accessed 1 October 2024.

6

Implementation roadmap

This section provides a high-level roadmap is presented below comprising key recommendations and implementation steps. For the purposes of this implementation roadmap, short-term is assumed to be less than two years; medium-term between two and five years, and long-term more than five years.

Table 6 High level implementation roadmap comprising key recommendations and implementation steps

Theme A: Workforce design, development, education and planning

Short-term	**1.** Health Ministers agree to the development of a National Skills and Capability Framework and Matrix (the Matrix) to support workforce design, development, education and planning in primary care.	G S/T
	3. The Health Ministers' Meeting (HMM) agree amendments to the National Law to provide a consistent authority of the HMM to give policy directions to the Australian Health Practitioner Regulation Agency (Ahpra) and National Boards in both registration and accreditation functions.	H
	4. Develop principles for Interprofessional Education (IPE) and interprofessional capabilities for primary care, collaborative practice and First Nations health care to contribute to contemporary and consistent cross-professional learning and practice.	B A E
	5. Remove unnecessary barriers to supervision in primary care education and training, including those that impede cross-professional supervision.	G S/T A E
	5.1 The Health Ministers' Meeting (HMM) request National Boards and accreditation authorities enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.	H B A
	5.2 Professional associations for self-regulated health professions to enable cross-professional supervision, where appropriate, to support education and training opportunities, including through the review of guidelines and accreditation standards that require (either explicitly or implicitly) supervision to be exclusively profession-specific.	B
	5.3 The Australian Government review MBS rules and guidelines to ensure that all health professions are reasonably and equitably supported to undertake workplace-based placement supervision.	G
Medium-term	**1.1** Establish an independent, national mechanism, reporting through to Health Ministers to create, maintain, develop and promote the Matrix.	G DH
	1.2 Implement an ongoing program of education, promotion and adoption of the Matrix to support awareness of and adoption by consumers, the health workforce, employers, and higher education providers and funders.	G S/T
	2. The Australian Government establish a primary care workforce development program to support the development and retention of a skilled, stable, and collaborative primary care workforce through the provision of enhanced curriculum, training/placement and career development capacities for students, supervisors/mentors and primary care health professionals.	G E
	4.1 The Health Ministers' Meeting (HMM) request accreditation authorities and National Boards reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant Continuing Professional Development (CPD) guidelines and requirements.	B H
	4.2 Professional organisations for self-regulated professions to reflect the principles for IPE and the interprofessional capabilities for primary care, collaborative practice and First Nations health care in relevant accreditation standards and guidelines, as well as in relevant CPD requirements.	B
Long-term	**1.3** National Boards and accreditation authorities regularly review the Matrix to align accreditation and registration functions relating to standards, codes, competencies and guidelines for nationally regulated health professions.	B A DH O
	1.4 Professional bodies, in their capacity as self-regulating entities, regularly review the Matrix to align accreditation and professional standards functions relating to standards, codes, competencies and guidelines for self-regulated health professions.	B A DH O

H Health Ministers' Meeting (HMM) responsibility
A Accreditation Authorities responsibility
I Independent Mechanism responsibility
G Australian Government responsibility
S/T State and territories responsibility
DH Dependent on HMM decision
B National Boards/Professional Organisations responsibility
E Higher education providers responsibility
O Ongoing

Theme B: Legislation and regulation

Short-term	**6.** Health Ministers agree to progress activity-based regulation of scope of practice to complement the status quo protection of title approach. This would apply in instances where a clinical activity that is to be regulated through Australia, State or Territory legislation, excluding the National Law or the NRAS: is effectively common or shared across a number of health professions, or has the potential to be; or is a novel clinical activity not currently performed or undertaken only by a single discipline; and meets an appropriate risk threshold; and is in the public interest consistent with the objectives of the National Law, S3 (2) [a-f].	G S/T
	6.1 Health Ministers agree to prospectively limit in future legislation and regulation the use of protected titles as the primary means of regulating and restricting activities in legislation unrelated to the National Law or the direct regulation of health professionals, i.e. *shorthand references* - and instead adopt an approach based on assessment and management of the inherent risk associated with the activity being regulated or restricted.	G S/T
	6.2 The Health Ministers' Meeting (HMM) request National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) to commence identification of activities falling within an overlapping scope across professions, to inform relevant programs of review and potential harmonisation of existing legislation and regulation (see Recommendation 7), guidelines and standards, and/or education programs.	H B
	7. Health Ministers agree to a program of review and potential harmonisation of existing legislation and regulation which contain unnecessarily restrictive application of *shorthand references*, and which if replaced by an activity-focused approach, would enable a wider range of health professionals to undertake the restricted activity consistent with their scope and in the public interest.	G S/T
	8. The Health Ministers' Meeting (HMM) agree to strengthen and standardise the regulatory model for health professions currently operating outside of the National Registration and Accreditation Scheme (NRAS) to enable the community to access and benefit from all health professionals working to their full scope of practice in multidisciplinary teams in primary care and ensure safety and quality of care delivered by the self-regulated health profession.	H
Medium-term	**7.1** Commence the program review and potential harmonisation of existing legislation and regulation with the following: Drugs & Poisons Acts, Radiation Safety Act, and Mental Health Acts.	DH G S/T
	8.1 The Health Ministers' Meeting (HMM) agree to commission a rapid impact analysis of the three reform options relating to self-regulated professions, to determine which option/s meet the criteria defined in Recommendation 8 and is cost-effective: **Option A** – targeted legislative amendments to introduce a pathway into the NRAS by introducing an additional criterion, such as a 'public interest' criterion, to the NRAS criteria for regulatory assessment of the need for statutory registration of a health profession **Option B** – Amended definition of a 'health profession' by amending the National Law to include additional specified professions in the definition of a 'health profession' **Option C** – accreditation by Ahpra (or another body) of relevant professional bodies to perform consistent, quality self-regulation functions for professions which are not nationally registered in the NRAS.	H
	9. Establish an Independent Mechanism to provide evidence-based advice and recommendations to Health Ministers, government and key stakeholder groups in relation to significant workforce innovation, emerging health care roles, and workforce models that involve significant change to scope, that: are high risk, or offer significant improvements to service access, consumer experience or productivity.	H
	9.1 Independent Mechanism to hold responsibility for developing the National Skills and Capability Framework and Matrix (Recommendation 1) as a priority initial activity.	I

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O Ongoing

Theme C: Funding and payment policy

Short-term	**10.** Introduce a new blended payment to enable access to multidisciplinary health care delivered by health professionals working to their full scope of practice in primary care. This new payment would be supported by a significant growth in investment in primary care and would shift the mix of Australian Government payments for primary care from a 90:10 fee-for-service: blended payment to the 60:40 (at an aggregate national level).	G
	10.1–10.3 Establish nominated fundholding entities (10.1), access requirements (10.2), and payment sources (10.3) for the new blended payment.	G
	10.4 Introduce a new practice level transition payment to ensure that the move from 90:10 to 60:40 ratio is supported by real growth in primary care investment.	G
	10.5 Establish an independent, specialised mechanism, or utilise an existing entity (such as IHACPA) to devise, calculate and maintain the risk stratification method for the blended payment, and determine prospective pricing adjustments and indexation of the Commonwealth payment.	G
	10.6 For historically underserviced areas with minimal or no access to MBS billing, GPs and health professionals implement an alternative registration model to ensure equitable access to the blended payment as the primary payment mechanism for Australian Government primary care programs.	G
	10.7 Incorporate the blended payment model into a new reform schedule of the National Health Reform Agreement (NHRA) to enable appropriate participation by and eligibility for State and Territory Local Health Networks (LHNs) and Primary Health Network (PHNs).	H
	12. The Australian Government implement new direct referral pathways for consumer access to specified non-GP specialist MBS items which meet the following criteria: (A) The direct referral made by the health professional is within their scope of practice, and (B) The referral is accompanied by appropriate, timely notification of the consultation to relevant treating team members, including the patient's GP, and registered practice via digital mechanisms, as available.	G
Medium-term	**10.8** Implement the blended payment model in a staged program over seven years commencing with rural and remote regions (Modified Monash Model 5-7), Aboriginal Community Controlled Health Organisations (ACCHOs), underserviced regional and outer metropolitan areas, and other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserviced communities and population groups.	G
	11. Introduce a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and public hospital settings.	G
	11.1 Introduce a private sector version of the bundled payment for maternity care. Amend the Private Health Insurance Act and Health Insurance Act to establish an eligible product in the Hospital Cover schedule which supports a bundled payment for maternity care, inclusive of the midwifery continuity of care model, traditional midwife plus medically led model, or a GP shared care model for combined, integrated, woman-centred care provided in primary care and private hospital settings.	G
	12.1 Implement new direct referral pathways in a staged program commencing with selected rural, remote areas and metro areas to evaluate effectiveness. Based on the evaluation of the targeted rollout, fully implement the new direct referral pathways.	G
Long-term	**10.9** Full implementation of the blended payment model across all regions for all in-scope primary care services.	G O
	10.10 Ongoing evaluation and monitoring of staged program of the blended payment model implementation.	G O

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S/T State and territories responsibility

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O Ongoing

Theme D: Enablers

Short-term	**13.** Governments and key stakeholders commit and agree to progress the reform program and governance structure to drive culture, leadership, implementation support and evaluation across the primary care system.	G S/T
	13.1 Australian, State and Territory governments agree to incorporate all relevant recommendations from this Review into the upcoming National Health Reform Agreement (NHRA), specifically into the respective schedules of the agreement which address agreed health system reforms.	G S/T
	15. Governments, working with relevant professional associations, develop and implement communications and training strategies about the intent and substance of reforms to strengthen multidisciplinary primary care teams working to full scope of practice.	G S/T B
	15.1 Embed a consumer co-design and consultation element in the design and implementation phases associated with all recommendations.	O
	16. The Health Ministers' Meeting (HMM) agree to progress work to commit to a shared definition of cultural safety based on the definition of cultural safety for the National Registration and Accreditation Scheme.	H
	16.1 The Health Ministers' Meeting (HMM) agree to incorporate cultural safety as a foundational shared capability in the first iteration of the National Skills and Capability Framework and Matrix.	H
	18. Governments commit to prioritise implementation of reforms in rural, remote and underserviced areas, and to engage with relevant organisations and stakeholders to collaboratively design implementation solutions specific to rural, remote and underserviced communities, commencing with Recommendations 2, 9, 10, 11, 12 and 14.	G
Medium-term	**14.** The Australian Government develops a new capacity building and implementation support program for the 31 PHNs that will complement their existing planning, integration, practice support and commissioning functions in the primary care system. Specifically, these include Recommendations 2, 10, 11, 12, 13, 17 and 18.	G
	17. The Australian Government mandates participation by all primary care providers in an accreditation program under the applicable Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation schemes, or other relevant accreditation programs i.e. National Safety and Quality Primary and Community Healthcare Standards, National General Practice Accreditation, and Quality Care Pharmacy Program.	G
	17.1 The Australian Government implements a program of capacity building for clinical governance, risk management and quality assurance across the primary care sector to be supported by PHNs or other appropriate bodies.	G

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O Ongoing

7
Conclusion

7. Conclusion

Providing safe, effective consumer-focused primary care relies on a skilled and stable workforce comprised of a range of health professionals who are supported to contribute their profession-specific skills and capabilities. Generations of practice and research have shaped the specific expertise of health professions and within each profession, individual health professionals further develop their expertise through experience, education and training. A health professional's scope of practice refers to the activities for which they are competent (educated, trained, experienced, confident), accountable and authorised. This will, understandably, change over time and is further influenced by the practice context, including jurisdictional policies and practice expectations. Highly functioning health care teams recognise and effectively utilise each team member's practice scope to shape the outcomes of the collective. Ensuring the primary care team is adequately prepared and effectively co-ordinated is essential to provide the care consumers and communities need.

Objective and method

Consistent with the objectives of *Strengthening Medicare*, this Review has explored how primary care health professionals can be enabled to work to their full scope of practice within multidisciplinary teams and how innovative workforce models can be designed, developed, planned and supported to evolve and respond to changing community need.

The Review consisted of four phases that explored and progressively refined a comprehensive understanding of the specific issues that inhibit primary care health professionals from working to their full scope, the challenges primary care teams face across a range of settings and the potential mechanisms that could address these challenges. The Review employed an iterative process that built findings based on review of the literature and evidence, and through extensive consultation and active synthesis. Throughout, the Review deliberately and consistently engaged with a broad and inclusive audience to shape the findings.

Findings

This Review has identified a range of issues that impact the ability of primary care health professionals to work to their full scope of practice. Stakeholders consistently expressed frustration at the inability to perform tasks for which they are trained and competent. Rather than changing or extending scope, stakeholders were focused on being supported to perform to their proven skills and capabilities.

While strongly interconnected, the issues identified can be grouped into the following broad themes:

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

The Review identified that all primary care professions, including GPs, face barriers or restrictions that prevent full scope of practice. Importantly, many of these barriers are unrelated to the skill, education, training, competence and accountability of the health professional. Barriers were noted to significantly shape the primary care workforce. For example, restrictions that prevent the delivery of specific primary care education and training result in an underprepared workforce. Without the opportunity to learn about primary care, a subtle, yet impactful, culture can develop that fails to value primary care as a rewarding career avenue.

Review findings also uncovered poor cross-professional recognition of skill and capability which leads to colleagues working together without a clear understanding of how they each can contribute to care. This uncertainty impedes clear expectations and interprofessional trust, with the potential to create confusion and significantly impact the function and outcomes of the multidisciplinary team. Poor understanding of professional skills and capabilities can also directly impact consumers, similarly creating confusion and potentially reducing confidence in the care system. Consultation frequently highlighted that, although teams are willing to work together, limited understanding of team members' scope can work to actively prevent this outcome.

The issues identified by this Review are experienced in different ways across the primary care system, with some professions significantly more impacted than others. For example, funding and payment policies can functionally restrict practice scope and prevent health professionals from contributing to the care provided by a multidisciplinary team. A consistent finding and general rule can be applied; fee-for-service payment models restrict scope and teamwork, while blended, bundled, block and salaried payment models enable scope and teamwork. Inconsistencies were also identified in the support available for education and training and for health professionals themselves, through the provision of supervision, mentoring and/or peer support. Additionally, overly prescriptive and inflexible legislation can prevent health professions from engaging in roles for which they are competent.

Differences were identified between the primary and acute care sectors in the support available for health professional education and training and in the mechanisms that support and enable effective clinical governance and risk management. Commonly, these were identified as more variable, basic, less resourced and voluntary in primary care. In the absence of these mechanisms, the risk falls on consumers, the health workforce and the taxpayer.

In addition to the commonly identified factors that impact scope, a less tangible, cultural factor is present. Where health professionals are prevented from performing tasks that fall within their full scope, an implicit view can develop that suggests those tasks are outside the scope of practice for the profession. This subliminal cultural view, commonly developed over many years and potentially held by both peers and consumers, can significantly impact primary care health professionals. For example, GPs have traditionally provided referrals to other health professionals for assessment and/or treatment, as part of their role as coordinators of primary care. Consequently, consumers may not view the provision of referrals as a core function of other health professions and may not recognise this function as part of their scope of practice. Yet most health professionals are educated and trained to recognise when referral provides best care, however the existence of rigid, and in many instances unnecessary, payment rules effectively prohibits the exercise of that scope.

Impact

A range of challenges will impact health care provision into the future. Providing the best possible health care for an ageing population and communities that experience increasing complexity of health needs will require the identification, exploration and implementation of new and enhanced models of care. To facilitate change, existing health policy will need to shift to better support all health professions to work to full scope of practice. In parallel, a culture that respects health professional skills and capabilities and supports practice at full scope is required.

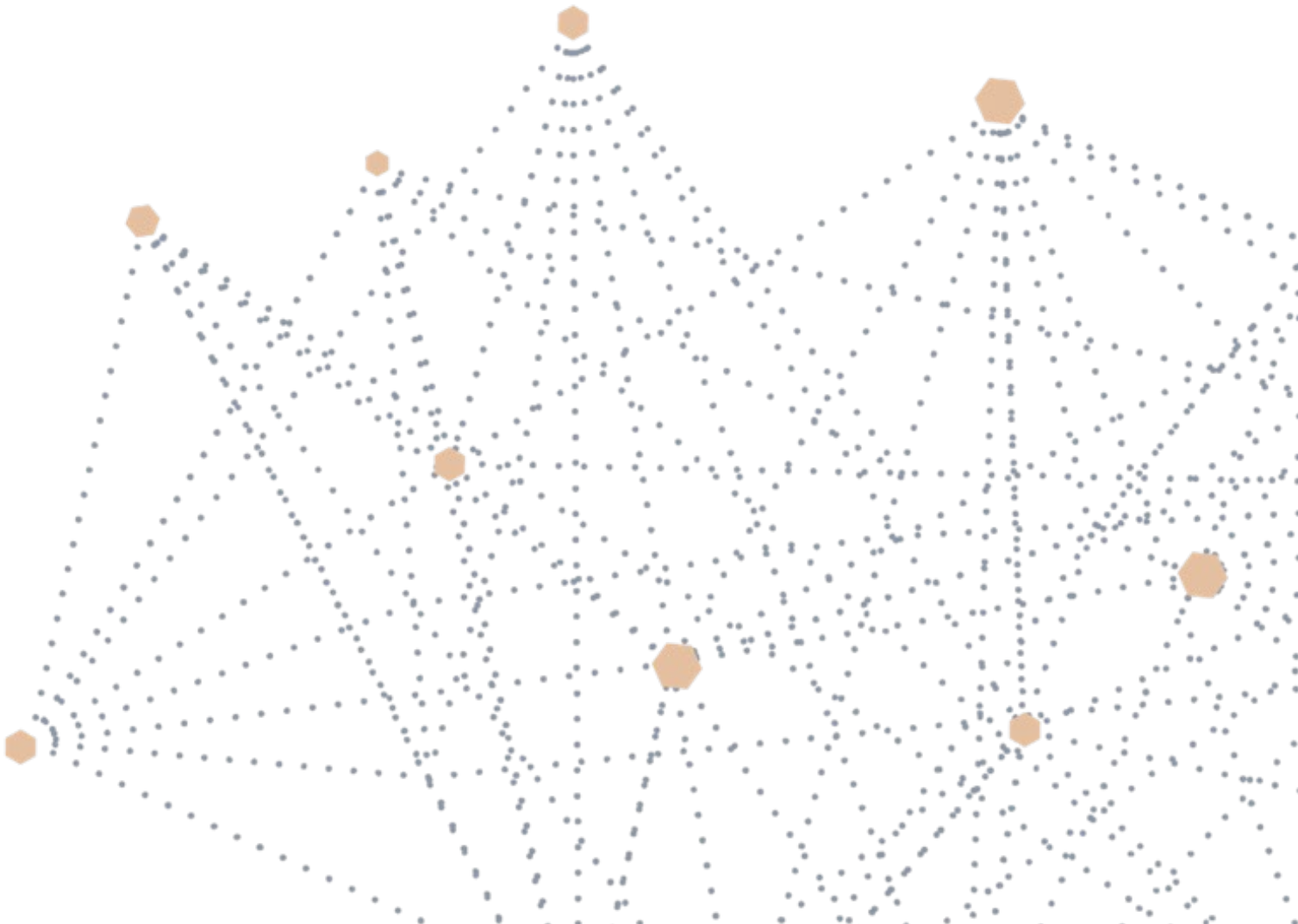
Many professions have individually faced, and addressed (or attempted to address), the issues identified in this report. Enacting change that enables health professions to work to full scope of practice provides learning opportunities for the entire health system. However, these opportunities have largely failed to contribute to a system-wide culture that enables health professionals to provide care according to their full scope of practice.

The impact of these findings on primary care include:

- **Restricted consumer access to optimal care** identified across the primary care system, and particularly for those living in regional and remote areas, where a health professional may be available, but not authorised or enabled to provide care that falls within their scope.
- **Reduced opportunity for multidisciplinary care.** Barriers restrict health professionals from working collaboratively as a multidisciplinary team and reinforce professional siloes.

- **Reduced workforce mobility, productivity and skills portability** resulting from inconsistent recognition of professional scope and/or qualifications gained through post-entry education, training and experience.
- **Poor workforce retention,** resulting from the inability to work to full scope which was viewed as demotivating and a strong influence on health professionals choosing to leave the health workforce. This is an avoidable waste, in a time of growing workforce scarcity.
- **Inadequate preparation for working in the primary care sector** due to poor value placed on the sector and limited practical experience in professional entry education and training programs, and inadequate opportunities to maintain and develop skills as early career professionals. This leads to hospitals as the default, and increasingly preferred, career choice for health professionals.
- **Differential adverse impacts on the self-regulated professions** in terms of the lack of essential recognition of their skills and competencies, their potential to contribute to comprehensive care and for consumers to benefit from them.

Despite the challenges identified, many examples of effective multidisciplinary teams, primary care training and support programs, and models of care that support health professionals to work to their full scope of practice were gathered. These included ACCHOs, primary care services offered in rural and remote areas, including rural generalist models, community health services that target higher risk, lower socioeconomic groups and innovative general practice models that support and/or provide a range of multidisciplinary services and optimise the use of primary care health professionals. The existence of such positive exemplars, operating as they do under the same barriers as the rest of the system, only underscores the untapped potential of our health workforce.



Recommendations for reform

Distilling the findings of the Review, a series of recommendations are proposed that seek to address the issues identified as significantly impacting the scope practice for primary care health professionals. Collectively, the recommendations provide a multifaceted approach to enacting achievable system wide change that strengthens the primary care health system by supporting health professionals to work to their full scope of practice in multidisciplinary teams centred around consumer and community care. The recommendations ultimately intend to enable the delivery of primary care with a renewed focus on the consumer and the provision of quality care delivered by skilled and collaborative multidisciplinary health care teams.

Opportunities and benefits of recommendations

The intent of the three key areas of reform is described below, using health profession-specific examples; however, the scope of reform is far from limited to these health professions. Overall, the combined recommendations seek to bring about system-level change which will support all primary care professionals to work to their full scope and multidisciplinary care teams to work together more effectively. Further, the combined recommendations will improve consumer access to the primary care they need and support the institutions underpinning our primary care system to be more responsive to good practice.

Workforce design, development, education and planning reform is critical to support all health professionals to have the opportunities and support they need to develop and maintain the skills to deliver primary care to their full scope of practice. The cornerstone of these reforms, the development of a National Skills and Capability Matrix and Framework (**Recommendation 1**), will underpin a consistent and clarified understanding of scope of practice at a national level. The proposed primary care workforce development program seeks to enhance the primary care-specific curriculum, education, training and career development capacities for all professions who work in primary care (**Recommendation 2**).

Recommendations in action

For instance, community paramedics have demonstrated value in providing primary care and community support for a range of health conditions and reducing the need for hospital attendance.[172, 173, 174] Particularly in rural and remote communities, the role of the community paramedic may address workforce issues.[175] Community paramedics would therefore benefit from improved access to primary care specific training and support to access training in rural and remote areas. Improved national-level clarity and transparency about their skills, capabilities and scope of practice will support the provision of care according to innovative models that move beyond the traditional role but remain consistent with competence (**Recommendation 1**). They also stand to benefit significantly from the following, via clarified Health Ministers' Meeting authority in relation to Ahpra accreditation functions (**Recommendation 3**):

- Access to consistent national education to support the community paramedic role, and consistent employment titles have been identified as important and currently lacking.[176] Supporting relevant accreditation standards and accompanying continuous professional development are also essential. (**Recommendation 4**).
- Access to professional supervision, which may include opportunities to be supervised by non-paramedics, or to contribute to the supervision of other professions (**Recommendation 5**), are of particular salience in the workforce-constricted rural and remote regions in which many community paramedics operate.
- An overall strengthened focus on learning together with other professions, which will help to break down an embedded cultural view of paramedic practice that focuses on the traditional emergency response rather than broader community roles.

Legislation and regulation are critical to protecting the public by ensuring safe and ethical professional practice, and a key source of scope of practice barriers and inconsistencies between jurisdictions. Reform in this area will seek to create a system which is more responsive to emerging models of care, and where there is clarity around professions' ability to work to full scope of practice regardless of their regulatory status. For example, a self-regulated profession stands to benefit from an activity-based approach to regulation to complement existing protected titles approach, as do all primary care professions (**Recommendation 6**). This activity-based approach, as applied initially through the targeted review and potential harmonisation of priority legislation and regulation (commencing with Drugs and Poisons, Radiation Safety and Mental Health acts), may clarify and explicitly authorise aspects of their scope of practice (**Recommendation 7**). The profession would be further supported directly by consideration of proposed options to support self-regulated professions through proposed changes to the regulatory approach which governs them (**Recommendation 8**). At the same time, the proposed Independent Mechanism for assessing emerging health workforce models will provide a more streamlined pathway into practice for emerging and innovative models of care involving that self-regulated profession as part of the multidisciplinary care team (**Recommendation 9**).

Funding and payment policy has a determinative impact on the ability for professions to work to full scope of practice. Funding and payment policy recommendations seek to bring about a primary care funding structure which is more aligned to the diversity of care delivered by multidisciplinary care teams, and which is both flexible and more supportive of consumers with complex health needs.

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[172] Bigham BL, Kennedy SM, Drennan I, Morrison LJ. (2013) Expanding paramedic scope of practice in the community: A systematic review of the literature. Prehospital Emergency Care. 17:361-71. https://doi.org/10.3109/10903127.2013.792890

[173] Blacker N, Pearson L, Walker T. (2009) Redesigning paramedic models of care to meet rural and remote community needs. Presentation, 10th National Rural Health Conference.

[174] McManamny T, Jennings, P.A., Boyd, L., Sheen, J., Lowthian, JA. (2018) Paramedic involvement in health education within metropolitan, rural and remote Australia: a narrative review of the literature. Australian Health Review. 44:114-20. https://doi.org/10.1071/AH17228

[175] Ibid.

[176] Spelten E, Thomas, B., van Vuuren, J., Hardman, R., Burns, D., O'Meara, P., Reynolds, L. (2024) Implementing community paramedicine: A known player in a new role. A narrative review. Australasian Emergency Care. 27:21-5. https://doi.org/10.1016/j.auec.2023.07.003

Recommendations in action

For example, the proposed new risk-adjusted blended payment (**Recommendation 10**) will address the growing role of nurse-led clinics as a model of delivering primary care. These clinics, in which nurses have responsibility for the care provided to a cohort of patients, are commonly community-based and supported by evidence indicating their benefits for consumers and regional and remote communities.[177, 178, 179] Currently, this model of care often fails to attract necessary funding and support, which confines nurses to a delegated primary care model that operates within general practice. The combined recommendations will improve the flexibility of the funding stream available to nurse-led clinics, rather than reliance on MBS, and will establish new direct referral pathways for nurse practitioners and remote area nurses which will support their ability to coordinate with the broader multidisciplinary care team (**Recommendation 11**).

Moreover, the proposed new bundled funding model for maternity services will directly support midwives and others working within midwifery continuity of care models or GP shared-care models to have consistency of funding when they work across primary care and hospital settings (**Recommendation 12**).

General practitioners (GPs) commonly undertake additional education and training in a variety of specific areas of interest such as dermatology and addiction medicine. They may also complete rural generalist training and achieve rural generalist fellowship. Recognition of these advanced skills is important to enable consumers to access the care they need and for GPs to contribute fully to the multidisciplinary team. The Matrix (**Recommendation 1**) would enable GPs to be recognised for all their skills and capabilities. The proposed new risk-adjusted blended payment (**Recommendation 10**) will support a transition to increased flexibility in funding to support general practices, including a targeted implementation pathway for rural and remote practices, and will better enable GPs to work alongside a multidisciplinary care team.

Meanwhile, a series of **enablers and other key considerations** will further support the scale of change required. Broad government and stakeholder commitment to change, emphasised by incorporating all relevant recommendations into the upcoming National Health Reform Agreement (**Recommendation 13**) will drive overall momentum. PHNs will be given a central role in supporting reform implementation and will receive targeted capability uplift to do so (**Recommendation 14**). Communications and training, and an embedded consumer co-design element, will support all implementation efforts (**Recommendation 15**). Cultural safety will be a focus of ongoing efforts to progress a primary care system-wide definition (**Recommendation 16**), building on existing efforts during the development of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.[180]

With the proposed new requirement for participation in a relevant accreditation program, supported by a PHN-led capacity building program, primary care providers will more consistently understand and deliver to appropriate scope of practice (**Recommendation 17**). Finally, a dedicated approach for rural and remote communities will apply to all relevant recommendations (**Recommendation 18**), acknowledging these are both the areas of greatest need and greatest immediate opportunity to establish and spread health workforce innovation and reform.

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[177] Beks H, Clayden S, Shee AQ, Binder MJ, O'Keeffe S, Versace VL. (2023) Evaluated nurse-led models of care implemented in regional, rural, and remote Australia: A scoping review. Collegian. 30:769-78. https://doi.org/10.1016/j.colegn.2023.05.004

[178] Connolly C, Cotter P. (2023) Effectiveness of nurse-led clinics on healthcare delivery: An umbrella review. Journal of Clinical Nursing. 32:1760-7. https://doi.org/10.1111/jocn.16186

[179] Randall S, Crawford T, Currie J, Betihavas V. (2017) Impact of community based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. International Journal of Nursing Studies. 73:24-33. https://doi.org/10.1016/j.ijnurstu.2017.05.008

[180] Ahpra & National Boards (2023) Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Accessed 1 September 2024.

Recommendations in action

One illustrative and topical example of the impact of intersecting scope of practice reforms is that of community pharmacy. Australia's more than 6000 community pharmacies provide the most accessible healthcare for communities in metropolitan, rural and remote areas. [181] Recent expansion to the services provided by community pharmacists has enabled them to provide care for a range of conditions commonly seen in primary care. Inconsistencies can be identified in how these services are provided. For example, in some jurisdictions pharmacists are authorised to prescribe an increased range of medicines for common conditions, such as urinary tract infections.

However, a combination of factors (including education and training, funding and payment policy and legislation and regulation) affects how these services are available to patients. The continuation of the current state is likely to result in consumer confusion, pharmacist frustration, fragmented care, inconsistent care provision and patient inequity. The combined recommendations put forward by this Review have the potential to strengthen how primary care is delivered in this setting, as in all other primary care settings.

In a primary care system where all recommendations proposed by this Review have been accepted, community pharmacists would have their competencies (including prescribing where relevant) clearly mapped and visible through the National Skills and Capability Matrix (**Recommendation 1**), allowing their skills and capabilities to be more fully recognised and translated into policy, practice and regulation. The development of a primary care workforce development program could enhance the supports for professional entry education and training, supervision, and early career development for community pharmacists (**Recommendation 2**), including in rural and remote areas. Pharmacist competence in shared areas of skill such as vaccination could be added to the current or next tranche of professional capabilities and translated systematically into CPD (**Recommendation 4**), increasing clarity around these capabilities and pathways to develop these. Community pharmacists could also benefit from resolved barriers to professional supervision, including cross-professional supervision (**Recommendation 5**).

An activity-based approach would overall support the ongoing regulation of community pharmacists in relation to prescribing (**Recommendation 6**), including jurisdictional consistency in relation to drugs and poisons and other priority legislation and regulation (**Recommendation 7**). They would be better supported to understand and work alongside their self-regulated colleagues, with increased clarity around which professions are educated, competent and authorised to deliver aspects of care (**Recommendation 8**). The introduction of a dedicated mechanism to assess health workforce models would fill a key gap in the system and would likely further contribute to the systematic consideration and translation into practice of multidisciplinary primary care models including pharmacists (**Recommendation 9**).

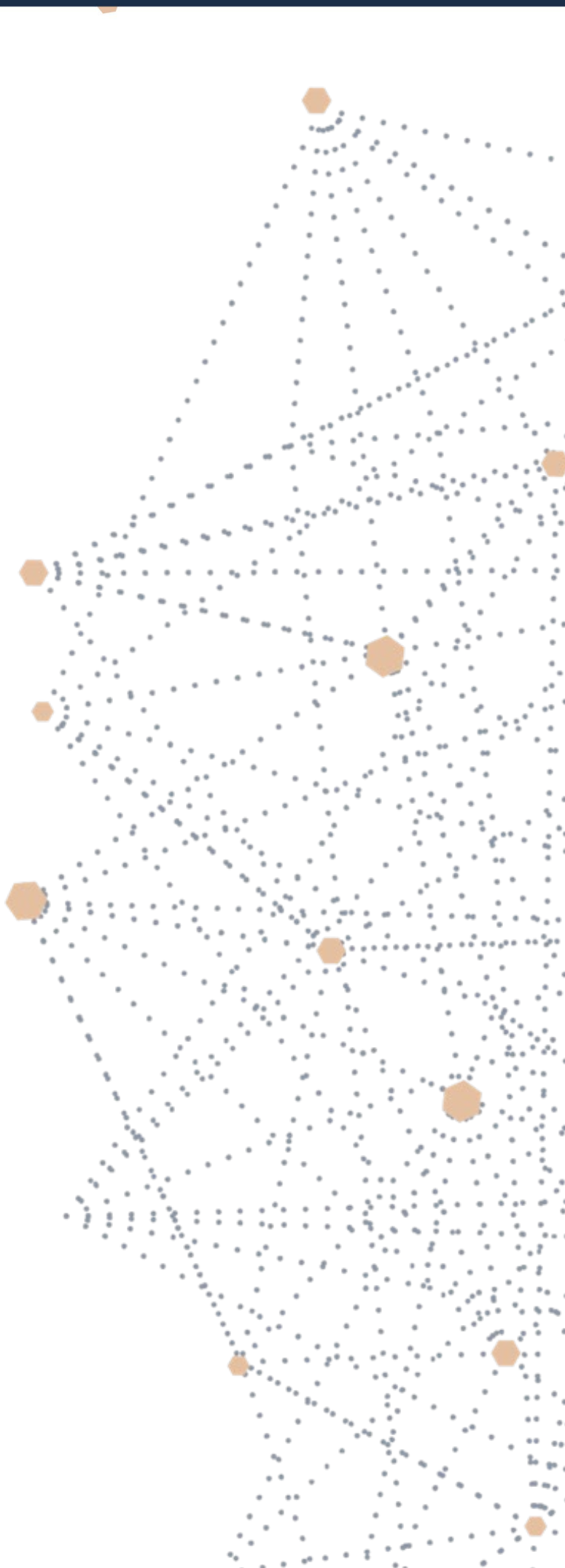
Reforms also broaden the opportunities for community pharmacists, as with all other professions, to work together with multidisciplinary care teams. Community pharmacists would be better supported to work in broader practice settings through more flexible blended and bundled funding models (**Recommendations 10 and 11**). New direct referral pathways and underpinning digital mechanisms would provide new opportunities for community pharmacists to integrate their scope of practice in the context of the health care team, utilising their specific medicines expertise (**Recommendation 12**). The range of recommendations targeting enablers and other considerations would provide critical support at a whole-of-system level for the implementation of all the above recommendations (**Recommendations 13-18**).

[181] Pharmacy Guild of Australia (2024) Fact sheets. Accessed 1 October 2024.

The impact of the combined recommendations is therefore to unlock, clarify and make consistent aspects of existing scope of practice, and improve interprofessional understanding and trust around it. Critically, reform will strengthen the ability and opportunities of community pharmacists to contribute to multidisciplinary team-based care. The same ultimate outcomes can be said of all primary care health professions, with overall benefits for consumers in accessing the care they need from their own primary care team, regardless of who it comprises.

Crucially, the recommendations have been developed to respect the primacy of the consumer and the critical function of the multidisciplinary team through careful consideration of a range of influential factors, including:

- Consumer and societal expectations of primary care and primary care professionals
- A realistic view of the resources required to address the issues identified
- Recognition of the need for communities to be supported by strong multidisciplinary teams into the future
- Recognition that there is a limited understanding of what health professionals can do, including between health professionals themselves
- Recognition that while a national approach to reform is required, local application of recommendations is important, particularly for First Nations and rural and remote communities.



Summary

In summary, a range of opportunities for primary care are presented in the recommendations, focused on the consumer and community, the multidisciplinary team and the broader healthcare system. Viewed together, the following outcomes can be expected from the recommendations.

Primary care that provides better care for consumers and communities by:

- Responding more effectively to community and consumer need, facilitated by greater recognition of primary care health professional skills and capabilities, and improved workforce planning introduced by the National Skills and Capability Framework and Matrix (Recommendation 1). This recommendation would also enable more effective planning for the specific needs of rural and remote and First Nations communities.
- Improving consumer access to primary care delivered by multidisciplinary care teams working together to full scope of practice (all Recommendations).
- Maintaining a highly skilled and stable primary care workforce and developing the necessary skills and capabilities of the workforce to meet current and future needs (Recommendations 2, 3, 4 and 5).
- Enabling an improved level of public trust through greater transparency provided by the Independent Mechanism (Recommendation 9).
- Improving access to appropriate care for those with complex health needs, facilitated by changes to the funding and payment structure for primary care (Recommendation 10).
- Providing more seamless care for consumers accessing maternity care across health sectors (Recommendation 11).
- Enabling straightforward, affordable and timely referral processes for consumers to access their required health professional (Recommendation 12).

Multidisciplinary teams are enabled to work more effectively together and respond better to consumer and community need by:

- Improved primary care skill development (including for future roles) and maintenance, facilitated by enhanced support provided by the primary care workforce development program (Recommendation 2).
- Better planning and team responsiveness facilitated by improved recognition of the skills and capabilities of the entire primary care team provided by the National Skills and Capability Framework and Matrix (Recommendation 1).
- Highly functioning, sustainable multidisciplinary teams comprised of a range of health professionals according to consumer need. Team members feel valued, supported and professionally fulfilled, are enabled to provide their proven skills and are fairly remunerated for their role. (Recommendations 1, 2, 4, 5, 6, 7, 8, 10, 11 and 12).
- Engaging in inclusive multiprofessional learning that is equitably supported across all team members (Recommendations 2, 4 and 5).
- Working collaboratively together to provide care that recognises, respects and trusts the skills and capabilities of other team members.
  The system enables collaboration through changes to direct referral mechanisms (Recommendations 4, 5, 8 and 12).

The health care system supports primary care by:

- Enabling evidence-based innovation, including the exploration of new models of care, by fully recognising the skills and capabilities available within the primary care team (Recommendations 1, 6, 7, 8, 9 and 10).
- Supporting efficiencies through a reduced reliance on episodic care and greater flexibility in the composition of the care team (Recommendations 10, 11 and 12).
- Supporting the authorising environment to enable health professionals to work according to their proven skill/capabilities (Recommendations 6, 7 and 9).
- Improving the responsiveness of relevant legislation and regulation (Recommendation 6, 7 and 9).
- Improving the consistency of relevant legislation and regulation, including cross-jurisdictional definitions (Recommendation 6 and 7).
- Providing better regulatory support for primary care professions who are currently self-regulating (Recommendation 8).

The way forward

The Review acknowledges that instrumental to achieving change is active leadership and commitment that facilitates a culture change at the system, profession, organisation and professional levels. Although the proposed recommendations would be undertaken at a national level, it is recognised that successful change will require tailoring to the local context. This is particularly important for First Nations and rural and remote communities. For this reason, strong and inclusive local leadership will play a critical role in implementing the proposed recommendations.

Rural and remote settings have provided illustrative examples of safe, effective primary care delivered by cohesive multidisciplinary teams and individual health professionals working to their full scope of practice. This setting provides opportunities for further and immediate positive change.

Strong governance at the system and clinical interfaces will support change and form a necessary component of the path to reform. Clear practice expectations and accountabilities, supported by relevant policies and procedures, will be essential to support reforms, particularly where the scope of health professionals change. In parallel, regular and ongoing quality assurance mechanisms, including the exploration and monitoring of reform outcomes, will be essential to inform future change and optimise care and safety.

A structured, inclusive approach to change management, supported by mechanisms that ensure all members of the primary care team, including consumers, are made aware of, and given the opportunity to explore and understand the changes, will be critical to success.

This Review provides a clear pathway for change and seeks the support of all stakeholders to ensure we unleash the potential of our health workforce for the future.

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University of Queensland Centre for the Business and Economics of Health

Professor Lisa Nissen
Dr Lynda Cardiff
Dr Belinda Gavaghan
Aimee Johnston
Amanda Griffiths
Hannah Beilby
Dr Jean Spinks
Johnny Van Savage

KPMG

Sarah Abbott
Michelle Tabone
Clare Exinger
Amelia Jackson
Jacqueline Roberts
Sanda Naing

KPMG Law

Felicity Cooper
Emily Bailey Hughes
Philip Jones-Hope

University of Queensland academic contributors

Dr Rachel Elphinston
Professor Katharine Wallis
Dr Priya Martin
Dr Nicole Stormon
Associate Professor Susan de Jersey
Associate Professor Judith Dean
Associate Professor Sjaan Gomersall
Dr Barbra Timmer
Dr Carmel Fleming

External academic contributors

Professor Vivienne Tippett
Professor Sharon Bentley
Dr Julie Cichero
Professor Cylie Williams
Dr Chris Edwards
Dr Kerry Hall
Dr Rosalie Boyce

Australian Government Department of Health and Aged Care

Kirsten Buckingham
Kristy Gray
Dr Siobhan Dickinson
Cia Kay
Vanessa Peters
Vanessa Van Der Zwart
Alex Jones
Kerri Kellett
Alana Pekar
Toby O'Brien
Megan McCarthy
Michelle Yim
Gerard Wilton
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Susan Greenaway

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Scott Sutherland

Reference List

ACSQHC (Australian Commission on Quality and Safety in Health Care) (2021) National Safety and Quality Health Service Standards (second edition). Accessed 1 August 2024.

ACSQHC (Australian Commission on Quality and Safety in Health Care) (2021) National Safety and Quality Primary and Community Healthcare Standards. Accessed 1 August 2024.

ACSQHC (Australian Commission on Quality and Safety in Health Care) (n.d.) Consumers and accreditation. Accessed 1 October 2024.

ACSQHC (Australian Commission on Quality and Safety in Health Care) (n.d.) Partnering with Consumers Standard. Accessed 1 August 2024.

ACSQHC (Australian Commission on Quality and Safety in Health Care) The National General Practice Accreditation Scheme. Accessed 1 August 2024.

Ahpra & National Boards (2022) Supervised practice framework. Accessed 15 September 2024.

Ahpra & National Boards (2023) Accreditation Committee Annual Report 2022-23. Accessed 15 September 2024.

Ahpra & National Boards (2023) Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Accessed 1 September 2024.

Ahpra & National Boards (2023) Glossary of accreditation terms. Accessed 24 July 2024.

Ahpra & National Boards (2024) Have your say: Guidance on developing professional capabilities. Accessed 15 September 2024.

Ahpra & National Boards (2024) Interprofessional Collaborative Practice Statement of Intent. Accessed 9 July 2024.

Ahpra & National Boards (2024) Public consultation now open - draft guidance on embedding good practice in clinical placements, simulation-based learning and virtual care in student health practitioner education. Accessed 15 September 2024.

APNA (Australian Primary Health Care Nurses Association) Transition to Practice Programs. Accessed 10 July 2024.

Australian Digital Health Agency (2023) National Digital Health Strategy 2023-2028. Accessed 18 July 2024.

Australian Digital Health Agency (2023) The Digital Health Blueprint and Action Plan 2023–2033. Accessed 18 July 2024.

Australian Digital Health Agency (2024) National Digital Health Strategy 2023-2028 Delivery Roadmap. Accessed 18 July 2024.

Australian Government (2022) Budget October 2022–23. Accessed 1 August 2024.

Australian Government (2024) Budget 2024-25: Budget Paper No. 2. Accessed 1 August 2024.

Australian Government. Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020, made under the Health Insurance Act 1973.

Australian Government. Health Insurance (Pathology Services Table) Regulations 2020, made under the Health Insurance Act 1973.

Australian Government. Health Practitioner Regulation National Law Act 2009 (Cth), sch 1 'Health Practitioner Regulation National Law', pt 1 'Preliminary', s 3 'Objectives', 2(f).

Australian Government. Health Practitioner Regulation National Law Section 3 (2) [a-f].

Australian Government Department of Education (2024) Australian Universities Accord. Accessed 22 July 2024.

Australian Government Department of Education (2024) Commonwealth Prac Payment. Accessed 12 July 2024.

Australian Government Department of Education (2024) National Skills Passport Consultation Paper. Accessed 22 July 2024.

Australian Government Department of Finance (n.d.) Health Practitioner Regulatory Settings Review. Accessed 1 August 2024.

Australian Government Department of Health (2019) Australia's Future Health Workforce Report – Midwives. Accessed 22 July 2024.

Australian Government Department of Health (2019) PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped Care. Accessed 18 July 2024.

Australian Government Department of Health (2022) National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031. Canberra, Commonwealth of Australia. Accessed 18 July 2024.

Australian Government Department of Health (2022) Health Workforce Data. Accessed 17 July 2024.

Australian Government Department of Health (2022) National Health Workforce Dataset. Accessed 17 July 2024.

Australian Government Department of Health and Aged Care (2017) National Immunisation Education Framework for Health Professionals. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (n.d.) Nurse practitioner and midwife PBS prescribing consultation survey. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (2022) National Medical Workforce Strategy 2021–2031. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (2022) Australia's Primary Health Care 10 Year Plan 2022–2032. Accessed 1 September 2024.

Australian Government Department of Health and Aged Care (2022) Strengthening Medicare Taskforce Report. Accessed 1 August 2024.

Australian Government Department of Health and Aged Care (2023) Birthing healthy and strong babies on Country. Accessed 1 August 2024.

Australian Government Department of Health and Aged Care (2023) Nurse Practitioner Workforce Plan. Accessed 1 August 2024.

Australian Government Department of Health and Aged Care (2023) About primary care. Accessed 1 August 2024.

Australian Government Department of Health and Aged Care (2023) Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025: Final Report. Accessed 18 July 2024.

Australian Government Department of Health and Aged Care (2023) Murray-Darling Medical Schools Network. Accessed 12 July 2024.

Australian Government Department of Health and Aged Care (2023) The Ngayubah Gadan Consensus Statement – Rural and Remote Multidisciplinary Health Teams. Accessed 15 September 2024.

Australian Government Department of Health and Aged Care (2024) Review of MBS allied health chronic disease management services. Accessed 15 September 2024.

Australian Government Department of Health and Aged Care (2024) National Nursing Workforce Strategy. Accessed 17 July 2024.

Australian Government Department of Health and Aged Care (2024) National Allied Health Workforce Strategy. Accessed 15 September 2024.

Australian Government Department of Health and Aged Care (2024) 2020-25 National Health Reform Agreement (NHRA). Accessed 17 July 2024.

Australian Government Department of Health and Aged Care (2024) Australian Immunisation Handbook. Accessed 16 September 2024.

Australian Government Department of Health and Aged Care (2024) Australian Technical Advisory Group on Immunisation (ATAGI). Accessed 16 September 2024.

Australian Government Department of Health and Aged Care (2024) Consultation Paper 1: Review of complexity in the National Registration and Accreditation Scheme. Accessed 20 September 2024.

Australian Government Department of Health and Aged Care (2024) National Immunisation Program Schedule. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (2024) National Rural Generalist Pathway. Accessed 12 July 2024.

Australian Government Department of Health and Aged Care (2024) Review of General Practice Incentives. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (2024) Rural Health Multidisciplinary Training (RHMT) program. Accessed 12 July 2024.

Australian Government Department of Health and Aged Care (2024) Supply and Demand Study General Practitioners in Australia. Accessed 1 October 2024.

Australian Government Department of Health and Aged Care (2024) The history of Medicare. Accessed 22 July 2024.

Australian Government Department of the Prime Minister and Cabinet (2023) Working together to deliver the NDIS – Independent Review into the National Disability Insurance Scheme: Final Report. Accessed 18 July 2024.

Australian Government Jobs and Skills Australia (n.d.) Jobs and Skills Atlas. Accessed 17 July 2024.

Australian Government Services Australia (2024) Practice Incentives Program Teaching Payment. Accessed 1 August 2024.

Australian Health Ministers' Advisory Council (2018) AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions. Accessed 11 July 2024.

Australian Institute of Health and Welfare (2024) Australia's health. Accessed 31 July 2024.

Australian Institute of Health and Welfare (2024) General practice, allied health and other primary care services. Accessed 20 September 2024.

Australian National Audit Office (2024) Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks. Accessed 1 August 2024.

Australian Pharmacy Council (2020) Standards for the Accreditation of Programs to support Pharmacist Administration of Vaccines. Accessed 1 October 2024.

Beks H, Clayden S, Shee AQ, Binder MJ, O'Keeffe S, Versace VL. (2023) Evaluated nurse-led models of care implemented in regional, rural, and remote Australia: A scoping review. Collegian. 30:769-78. https://doi.org/10.1016/j.colegn.2023.05.004

Bigham BL, Kennedy SM, Drennan I, Morrison LJ. (2013) Expanding paramedic scope of practice in the community: A systematic review of the literature. Prehospital Emergency Care. 17:361-71. https://doi.org/10.3109/10903127.2013.792890

Blacker N, Pearson L, Walker T. (2009) Redesigning paramedic models of care to meet rural and remote community needs. Presentation, 10th National Rural Health Conference.

Bourgeault IL, Mulvale G. (2006) Collaborative health care teams in Canada and the USA: Confronting the structural embeddedness of medical dominance. Health Sociology Review. 15(5):481-95. https://doi.org/10.5172/hesr.2006.15.5.481

Carlton A, Leslie K, Bourgeault IL, Balasubramanian M, Mirshahi R, Short SD, et al. (2024) Health Practitioner Regulation Systems. A large-scale rapid review of the design, operation and strengthening of health practitioner regulation systems. Canadian Health Workforce Network. Section 116 (a). Accessed 11 July 2024.

CIHC (Canadian Interprofessional Health Collaborative) (2024) CIHC Competency Framework for Advancing Collaboration. CIHC website, Accessed 9 July 2024.

CIHI (Canadian Institute for Health Information) (n.d.) Legislated scopes of practice across Canada: Registered nurses. Accessed 22 July 2024.

Clifford-Motopi A, Brown R, White A, Harald P, Butler D, Mathew S, et al. (2024) Aboriginal and Torres Strait Islander community members' experiences of care in an urban Aboriginal Community Controlled Health Service transforming to a Patient Centred Medical Home. Australian Journal of Primary Health. 30. PY23163.

Commonwealth Consolidated Regulations (2018) HEALTH INSURANCE REGULATIONS 2018 - REG 96. Accessed 1 October 2024.

Connolly C, Cotter P. (2023) Effectiveness of nurse-led clinics on healthcare delivery: An umbrella review. Journal of Clinical Nursing. 32:1760-7. https://doi.org/10.1111/jocn.16186

Covidence Veritas Health Innovation Ltd. Covidence. Available from: https://www.covidence.org/, accessed 1 May 2024.

Craig KJT, Willis VC, Gruen D, Rhee K, Jackson GP. (2021) The burden of the digital environment: A systematic review on organization-directed workplace interventions to mitigate physician burnout. Journal of the American Medical Informatics Association. 28(5):985-97. https://doi.org/10.1093/jamia/ocaa301

Damschroder LJ, Aron DC, Keith RE, Kirsch SR, Alexander JA, Lowery JC. (2009) Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Science. 4:50. https://doi.org/10.1186/1748-5908-4-50

EIPEN (European Interprofessional Practice & Education Network) (2021) The EIPEN key competences for interprofessional collaboration. Accessed 9 July 2024.

Ford J, Gray R. (2021) Interprofessional Education Handbook: For educators and practitioners incorporating integrated care and values-based practice. CAIPE Publications: Centre for the Advancement of Interprofessional Education (CAIPE); 2021.

Government of Nova Scotia (2023) New Legislation Standardizes Regulated Bodies for Health Providers, Improves Protections for Patients. Accessed 09 July 2024.

Government of South Australia Allied and Scientific Health Office (2023) Allied Health Advanced Clinical Practice Statewide Framework: SA Health. Accessed 22 July 2024.

Health Education England, NHS England, NHS Improvement, Skills for Health (2021) Primary Care and General Practice Nursing Career Core Capabilities Framework. Accessed 22 July 2024.

Health Education NHS England and Skills for Health (2020) Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care in England. Accessed 22 July 2024.

Health Policy Analysis (HPA) (2022) Allied health workforce data gap analysis: Issues Paper. Report to the Australian Government Department of Health. Accessed 4 July 2024.

Health Professions Accreditation Collaborative (HPAC) Forum (2018) Position statement on interprofessional education. Accessed 9 July 2024.

Health Professions Accreditation Collaborative (HPAC) Forum (2020) Interprofessional Education (IPE): Report on the findings of a survey of HPAC Forum members. Accessed 9 July 2024

Health Professions Accreditation Collaborative (HPAC) Forum (2024) Developing a collaborative health practitioner through strengthened accreditation processes. Accessed 20 September 2024.

Heart of Australia (2022). https://heartofaustralia.com.au/, Accessed 15 September 2024.

Hilton K, Anderson A (2018) IHI Psychology of Change Framework to Advance and Sustain Improvement. Boston, Massachusetts: Institute for Healthcare Improvement.

Independent Hospital Pricing Authority (2017) Bundled pricing for maternity care: Final Report of IHPA and the Bundled Pricing Advisory Group. Accessed 18 July 2024.

IPEC (Interprofessional Education Collaborative) (November 2023) IPEC Core Competencies for Interprofessional Collaborative Practice, Version 3. Accessed 10 July 2024.

KBC Australia (September 2022) Increasing Dental and Oral health training in rural and remote Australia: Feasibility study. Report commissioned by the Australian Government Department of Health and Aged Care, Accessed 12 July 2024.

Kent F, Cardiff L, Clark B, Gustavs J, Jolly B, Maundu J, et al. (2024) Accreditation as a lever for change in the development of the collaborative practitioner in the Australian health system. Australian Health Review. https://doi.org/10.1071/AH24165.

Marathon Health (2024) Enabling communities to thrive through health and wellbeing. Accessed 12 July 2024.

Mathew S, Barzi F, Clifford-Motopi A, Brown R, Ward J, Mills R, et al. (2023) Transformation to a patient-centred medical home led and delivered by an urban Aboriginal and Torres Strait Islander community, and association with engagement and quality-of-care: quantitative findings from a pilot study. BMC Health Services Research. 23(959). https://doi.org/10.1186/s12913-023-09955-x

McManamny T, Jennings, P.A., Boyd, L., Sheen, J., Lowthian, JA. (2018) Paramedic involvement in health education within metropolitan, rural and remote Australia: a narrative review of the literature. Australian Health Review. 44:114-20. https://doi.org/10.1071/AH17228

Mental Health Professionals Network (n.d.) Mental Health Professionals' Network. Accessed 16 July 2024.

National Placement Evaluation Centre (2024) The Australian National Placement Evaluation Centre. Accessed 15 September 2024.

Nelson S, Turnbull J, Bainbridge L, Caulfield T, Hudon G, Kendel D, et al. (2014) Optimizing scopes of practice: New models of care for a new health care system. Canadian Academy of Health Sciences Ottawa, Accessed 1 August 2024.

New Zealand Government Manatu Hauora Ministry of Health (2023) Regulating a new profession. Accessed 11 July 2024.

New Zealand Parliamentary Counsel Office. (2023) Health Practitioners Competence Assurance Act 2003, Section 116 (a). Accessed 11 July 2024.

NHS England (2017) Multiprofessional framework for advanced clinical practice in England. Accessed 22 July 2024.

NHS England (2023) NHS Long Term Workforce Plan. Accessed 20 September 2024.

NSW Government (2020) Allied Health Assistant Framework. Accessed 15 September 2024.

NSW Government (n.d.) Pareto charts & 80-20 Rule. Accessed 20 September 2024.

O'Keefe M, Henderson A, Chick R. (2017) Defining a set of common interprofessional learning competencies for health profession students. Medical Teacher. 39(5):463-8

Office of the Chief Allied Health Officer Clinical Excellence Queensland (2022) Allied Health Assistant Framework. Accessed 9 July 2024.

Pharmacy Guild of Australia (2024) Fact sheets. Accessed 1 October 2024.

Pharmacy Guild of Australia (2024) Rural and Indigenous Health. Accessed 1 October 2024.

Pharmacy Programs Administrator (2022) National Immunisation Program Vaccinations in Pharmacy (NIPVIP) Program. Accessed 1 October 2024.

Pharmaceutical Society of Australia (2020) Practice Guidelines for the provision of immunisation services. Accessed 16 September 2024.

Pharmaceutical Society of Australia (2023) Professional Practice Standards 2023 (Version 6). Accessed 16 September 2024.

Queensland Government (2023) Allied Health Rural Generalist Pathway, health.qld.gov.au. Accessed 12 July 2024.

Queensland Health (n.d.) Strength with Immersion Model (SwIM) Programs. Accessed 10 July 2024.

RVTS (Remote Vocational Training Scheme) (n.d.) Fellowship training for doctors in rural, remote and First Nations communities. Accessed 1 August 2024.

Randall S, Crawford T, Currie J, Betihavas V. (2017) Impact of community based nurse-led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. International Journal of Nursing Studies. 73:24-33. https://doi.org/10.1016/j.ijnurstu.2017.05.008

Royal Australian College of General Practitioners (2024) General Practice Health of the Nation: An annual insight into the state of Australian general practice. Accessed 1 September 2024.

Royal Australian New Zealand College of Obstetricians Gynaecologists (2024) The RANZCOG mentoring program. Accessed 10 July 2024.

SARRAH (Services for Australian Rural and Remote Allied Health) Building the rural and remote allied health assistant workforce. Accessed 1 August 2024.

Scott A, Taylor T, Russell G, Sutton M. (2024) Associations between corporate ownership of primary care providers and doctor wellbeing, workload, access, organizational efficiency, and service quality. Health Policy. 142:105028. https://doi.org/10.1016/j.healthpol.2024.105028

Skills for Health (n.d.) Employability Skills Matrix for the Health Sector. Accessed 22 July 2024.

Smith D, Couzos, S., Tremlett, M., Loller, H., Stephens, M., Nugent, A., Vaughan, F., Hendrie, D., Buttner, P., Biros, E. (2020) Integrating pharmacists within Aboriginal Community Controlled Health Services to improve chronic disease management (IPAC) project. Accessed 31 July 2024.

Snowball K. (2014) Independent Review of the National Registration and Accreditation Scheme for Health Professionals Final Report.

Southcentral Foundation (2022) A deep dive on Nuka system of care performance data. Accessed 1 August 2024.

Spelten E, Thomas, B., van Vuuren, J., Hardman, R., Burns, D., O'Meara, P., Reynolds, L. (2024) Implementing community paramedicine: A known player in a new role. A narrative review. Australasian Emergency Care. 27:21-5. https://doi.org/10.1016/j.auec.2023.07.003

STAHF (Steering Team for Allied Health in Primary Care Engagement Framework) (2022) National PHN Allied Health in Primary Care Engagement Framework. Accessed 9 July 2024.

Victoria Department of Health (2024) Supervision and delegation framework for allied health assistants. Accessed 15 September 2024.

Victoria State Government (2024) Community health services. Accessed 31 July 2024.

Victoria State Government. Department of Health (2023) Introduction to the capability framework. Accessed 22 July 2024.

Wilson M, Mazowita G, Ignaszewski AP, Levin A, Barber C, Thompson D, et al. (2016) Family physician access to specialist advice by telephone: Reduction in unnecessary specialist consultations and emergency department visits. Canadian family physician Medecin de famille canadien. 62:e668-e76. https://pubmed.ncbi.nlm.nih.gov/28661886/

World Health Organization (n.d.) Primary care. Accessed 1 August 2024.

World Health Organization (2010) Framework for action on interprofessional education and collaborative practice. Accessed 10 July 2024.

World Health Organization (2020) Global strategy on human resources for health: Workforce 2030. Accessed 15 September 2024.

Woods M (2017) Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions - draft report. Accessed 20 September 2024.

Appendices

Appendix A
Expert Advisory Committee

Committee Member	Organisation
Professor Mark Cormack (Chair)	Independent Review Lead
Dr Fei Sim	Pharmaceutical Society Australia
Dr Nick Yim	Australian Medical Association
Mr Karl Briscoe	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Dr Nicole Higgins	Royal Australian College of General Practitioners
Mr Paul Gibson	Indigenous Allied Health Australia
Adjuct Associate Professor Alan Eade ASM	Australasian College of Paramedicine
Mr Blake Adair-Roberts	Health Services Union
Dr Elizabeth Deveny	Consumer Health Forum
Ms Alison Weatherstone	Australian College of Midwives
Ms Amanda Seeto	Pharmacy Guild of Australia
Professor Jane Mills	La Trobe Rural Health School
Ms Annie Butler	Australian Nursing and Midwifery Federation
Dr Catriona Davis-McCabe	Representative – Allied Health
Ms Susi Tegen	National Rural Health Alliance
Professor Adam Elshaug	Melbourne School of Population and Global Health
Ms Peta Rutherford	Rural Doctors Association of Australia
Ms Bronwyn Morris-Donovan	Allied Health Professions Australia
Professor Marion Gray	Australian Council of Deans of Health Sciences
Ms Marni Tuala	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Ms Denise Lyons	The Australian Primary Health Care Nurses Association
Ms Emma Barritt	CRANAplus
Dr Zoe Bradfield	Curtin University - Midwifery
Ms Marita Cowie	Australian College of Rural and Remote Medicine

Appendix B
Summary of review phases

The Current State

The Review team undertook an extensive program of consultation, research and evidence review to explore the issues that impact the ability of health professionals to work to their full scope of practice. The Review included four rounds of extensive consultation with a breadth of stakeholders since its commencement in September 2023. Consultation highlighted a range of issues affecting the delivery of primary care and uncovered many specific recommendations for improvement in line with the vision for primary care expressed by *Strengthening Medicare*. The following provides additional detail describing the early phases of the Review process (Phases 1 and 2). Phases 3 and 4 are described in *Section 4. The case for change*.

Review Phase 1 (September - December 2023)

This phase gathered feedback pertaining to the benefits, risks, barriers and enablers of enabling full scope of practice in primary care.

Benefits

Early submissions and face-to-face consultations identified a common view that supporting primary care health professionals to work to their full scope of practice would maximise use of the entire primary care workforce, noting that for some professions, significant barriers currently impede this. Enabling health professionals to work in a way that is consistent with their education, training and proven competence was identified as a facilitator of improved multidisciplinary team function and streamlined care pathways. These factors were identified as ultimately creating an improved consumer health care experience and confidence in the health system.

Risks

Participants identified a range of potential risks to consumers, health professionals, the health care team and broader health workforce, if health professionals worked to their full scope of practice, or if changes to practice scope were not effectively supported and implemented. Stakeholders from medical professions highlighted potential risks to *consumer safety*, including the possibility of missed diagnoses, misdiagnoses, greater complications, fragmentation of care and suboptimal follow-up. Other stakeholders countered this view, noting the significant education and training completed by health professionals in preparation for their roles and as part of ongoing professional development.

Risks to the *consumer experience* included possible confusion about the role of primary care providers, where these do not align with traditionally accepted views. Access to required education and training to support practice scope was identified as differing between professions and sole primary care providers were noted to experience practical challenges in completing CPD. These issues were viewed as impacting *health professionals* and limiting full scope practice, with a resultant impact on the *health care team*.

Other potential risks of enabling full scope of practice for the health care team included poor collaboration resulting from traditional professional hierarchies, limited understanding of and trust in professional roles, concerns regarding scope overlap, and/or perceived threat to established professional roles and boundaries.

These risks were seen as potentially detrimental to the overall function of the health care team and likely to impact the quality of consumer care. Risks to the broader health workforce were also suggested to result from a failure to adequately recognise health professional skills and qualifications (including across jurisdictions) or placing unrealistic expectations on those for whom full scope is enabled. These two potential risks were seen as impacting health care team sustainability.

Barriers and enablers

A range of barriers and enablers to health professionals working to full scope of practice were identified in Phase 1 consultation. Many of the identified barriers were key levers which, if resolved, had the potential to enable full scope of practice.

Funding and payment mechanisms considered as barriers to full scope of practice included an overreliance on fee-for-service funding via the MBS, a perceived lack of funding parity across professions and exclusion of professions from the MBS for specific items.

Enablement to potentially address these barriers was canvassed as greater cross-professional equity in access to MBS or other funding structures, and amendments to Chronic Disease Management Plans (CDMPs).

Legislation and regulation barriers included inconsistent terminology, definitions, competencies, education and practice expectations, which were seen to impact both the perception of roles and the ability to undertake practice consistent with education, training and competence. Inconsistent credentialling requirements across professions, employers and care delivery settings was raised as severely impacting health professional practice.

Differences in legislation were identified as potentially impacting the consistency of care provided across jurisdictions, and the ability of health professionals to refer consumers for care, including imaging and pathology investigations. Inconsistencies in drugs and poisons legislation was a frequent focus of consultation feedback, with many identifying an impact on practice and the application of research across jurisdictions.

Consultation frequently heard that the removal of barriers to referral for some professions and harmonising drugs and poisons legislation would enable health professionals to work to their full scope of practice.

Education and Training barriers identified included access to, and recognition of, education, training and CPD as fundamentally important to supporting health professionals to work to their full scope of practice. Educational experiences in primary care, including structured learning opportunities, curriculum content relating to primary care, and rural and remote opportunities were identified as lacking in many pre-professional entry education programs and post-qualification education. Training to support full scope was furthermore noted to be inaccessible and/or unavailable. Commonly, post-qualification education and training was not recognised and valued.

Enablement to potentially address these barriers were canvassed as adequate funding for placement experiences in primary care, adequately resourced supervision, networking and mentorship to support the primary care workforce and support for innovative models of supervision, including via virtual remote mechanisms. Enabling the development, delivery and access to education and training to support all health professionals was considered critical. General support was provided for the proposed national skills passport to contribute to greater acknowledgement and recognition of skills and qualifications, including across jurisdictions. Adequate and readily accessible recognition of skills and capabilities was considered an important contributor to more consistent acknowledgement of qualifications and reduced repeat credentialing at the local level.

Workforce culture, leadership, management and readiness were all factors raised in the context of potential barriers to optimal primary care function. A lack of professional representation, for example on workforce planning committees, was noted to prevent some professions from engaging in positive cultural change and interprofessional collaboration. Staff retention and remuneration were also identified as workplace issues that could serve as barriers to reform.

Dominant model of care was broadly described as relating to system-wide factors that prevent care provided by multidisciplinary teams. This was identified as requiring attention in addition to reforms to scope of practice, including enhanced roles for multidisciplinary teams and increased funding to support multidisciplinary case conferencing. These factors were seen as preventing the provision of best possible care, and particularly described in the context of consumers who have complex health needs.

Technology related to the sharing of health information, supported by effective information technology, is considered essential to support multidisciplinary care. Access to clinical details, secure messaging and the underuse of My Health Record were noted as barriers to team-based care.

Culture related barriers potentially impacting reforms included professional territorialism and the potential for professional boundaries to be fiercely protected in what were frequently referred to as ‘turf wars’. Poor recognition of professional capabilities was recognised and considered a barrier to team-based care.

Review Phase 2 (January – March 2024)

Phase 2 consultation presented five proposed areas for reform and harnessed further feedback specifically about these proposals. The reform areas and associated feedback are presented below.

Legislation and regulation

Legislation and regulation were confirmed as core elements of the authorising environment for health professionals to work to full scope of practice. Stakeholders consistently described the rigidity of the legislative and regulatory environment, its lack of responsiveness to new models of care and evidence, and inconsistencies in legislation and regulation as key barriers to working to full scope of practice. Overly restrictive or specific legislation which limits scope of practice for particular professions, settings, employers, or named medicines were viewed as a key area for change.

Legislative and regulatory barriers were described as having widespread impacts and ultimately leading to reduced consumer access, particularly in rural and remote areas with less choice of health professionals available.

The following potential areas for reform were proposed and feedback obtained through submissions and structured consultation.

Harmonising drugs and poisons legislation

This was the most strongly supported solution in this theme and generally viewed as the highest priority, considered highly impactful with the potential to significantly improve health professionals' ability to work to their full scope, and to do so consistently across jurisdictions.

Introducing risk-based & activity based regulatory processes

Introducing risk-based and activity-based regulatory processes was seen as having the potential to significantly support the ability of health professionals to work to full scope of practice, albeit with some potential risks which would require careful consideration in how this solution may be implemented.

Streamlining endorsement processes

Streamlining endorsement processes, for example local credentialling requirements, was a priority for professions directly affected by authorisation rules perceived as arbitrary or inconsistent and which have the potential to significantly impact the ability to work to full scope of practice.

Reviewing authorising environments for health professions outside of the NRAS

There was broad agreement that authorising environments in self-regulated professions were preventing full scope of practice, particularly where shorthand references to protected titles as defined in the National Law are embedded in legislation. For example, where legislation refers to registration or to the National Law, self-regulated professions are excluded. This may occur in relation to activities that fall within the scope of a self-regulated profession and therefore prevents those professions from undertaking that activity. Consensus was not reached on whether bringing additional professions under the NRAS would positively or negatively impact self-regulated professions or the NRAS as a whole.

Employer practices and settings

Significant barriers at the employer level were noted to impact health professionals' scope of practice. Barriers to working across different health settings, and for different employers were well described, and identified as restricting individuals and teams from working to their full scope of practice. For example, limited availability of positions that reflect full scope, and workforce shortages that require health professionals to fulfill roles of a more limited scope were viewed as frustrating. Further, remuneration inconsistent with skills and capabilities was noted to prevent health professionals from working to their full scope and was viewed as a barrier to completing additional education and training to reach full scope. There was broad agreement for improving consumer-centred care by applying a needs-based lens to primary care. Inconsistent recognition of health professional capabilities and qualifications was viewed as a barrier to full scope of practice.

The intersection of this area with other themes was highlighted and noted to impact employer practices. Professional culture and leadership were also noted to underpin employer practices, making this a key consideration in how to address the above policy problems.

The following potential areas for reform were proposed and feedback obtained through submissions and structured consultation.

Establishing more consistent approaches to recognition of qualifications and competencies across settings

A national regulatory approach to the definition of scope for individual professions, linked to education and training, was viewed as an important contributor to recognising the contribution of health professionals within the primary care team. Establishing a more consistent approach to the recognition of qualifications across settings was viewed as providing clarity about the role of individual professions and improving overall team function. For example, improved recognition and understanding of skills, capabilities and competencies across professions and jurisdictions could prevent health professionals from attaining a requirement to complete unnecessary, sometimes inconsistent local assessment/credentialling processes. This was identified as having the potential to improve health workforce capacity and mobility.

Establishing models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers

Participants were highly supportive of multidisciplinary care models. Improvements in interprofessional trust, understanding and respect, alongside improved consumer experiences of care and health outcomes, were commonly viewed as key potential impacts of models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers.

Strengthening clinical governance mechanisms in primary care settings

Supporting health professionals through more effective, systematic clinical governance mechanisms was viewed as providing structural strength for the primary care team and significant patient safety assurances. Stronger clinical governance would also serve to address some of the perceived risks associated with more health professionals working to their full scope of practice.

Education and training

Under-utilisation of skills of some in the current primary care workforce, resulting from a poor understanding of role and/or a failure to fully recognise skills acquired through education, training and experience, was described as demotivating and a risk to workforce stability and retention of an already undersupplied health workforce.

Health professionals reported facing significant challenges in accessing required and/or desired education and training, including that required to meet mandatory continuing education requirements. Consequently, health professionals are prevented from developing the skills and knowledge they need to support or enhance their scope of practice in primary care.

A commonly expressed concern was that, for some professions, students face significant challenges in completing required practical training as part of the pre-entry curriculum. Challenges described include inadequate supervised experiential learning ('placement') opportunities in primary care settings or the need to travel, at own expense, to complete training. The impact of these challenges includes unsuccessful completion of the program or a significant financial and personal burden to do so. Markedly fewer opportunities for students to complete practical training in primary care was identified compared to in hospitals, resulting in fewer graduates equipped for work in this setting.

The following potential areas for reform were proposed and feedback obtained through submissions and structured consultation.

Establishing mechanisms that support primary care experiences in pre-professional entry education and training programs

Improving the visibility of primary care in early education and training was viewed as important to provide health professional graduates with an understanding of the sector and to secure a stable primary care workforce. Providing opportunities for students to complete practical training in primary care was supported as an area for reform.

Establishing greater clarity about post-entry learning

In addition to promoting a greater appreciation of health professional skill, establishing greater system-wide clarity about the requirements for post-professional entry learning was linked to workforce mobility, flexibility and responsiveness. Stakeholders noted that employment opportunities across jurisdictions may be more attractive where qualifications are readily recognised.

Establishing a nationally consistent approach to promoting and implementing common interprofessional competencies

This reform option was widely supported as contributing to a strong primary care team that understands and respects the contribution of each profession and has the skills to work cohesively to meet consumer and community need.

Promoting multi-professional learning

The importance of multi-professional learning as a contributor to strong collaboration in primary care was acknowledged by most participants. Stakeholders recognised that post-professional entry education and training is commonly, although not exclusively, provided in a profession-specific manner which fails to contribute to a team approach to care. Effective technology support was identified as an important enabler of multiprofessional learning and collaborative practice in general.

Ensuring ongoing education and training are accessible

This reform option was viewed as an important mechanism to support the individual to maintain and advance their skills, and the primary care team to achieve its optimal capacity.

Funding policy

Most stakeholders felt strongly that funding policy reform was required to effect any change to health professionals' ability to work to full scope of practice. Funding policy was viewed as one of the core components of the authorising environment, alongside legislation and regulation, which was expected to have the greatest impact on scope of practice. It was noted that policy solutions in any other area would not be achievable without funding reforms.

Broad support was expressed throughout the consultations for all four proposed policy solutions, which were each seen as enabling different aspects of scope of practice. This was underpinned by overarching support for the multidisciplinary care team model, and support for greater flexibility via funding mechanisms to drive better utilisation of all members of the health care team.

The following potential areas for reform were proposed and feedback obtained through submissions and structured consultation.

Using block, bundled and blended funding to deliver care flexibly

There was strong support for a range of alternative funding mechanisms, particularly those that contained a block funding component as a complement to fee-for-service payments which were broadly seen as restricting scope.

Funding and payment types which enable working as multidisciplinary care teams

Stakeholders expressed strong support for the principle of multidisciplinary care teams and raised several potential funding models they saw as supporting team-based care, particularly payment for advice or care coordination.

Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules

Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules was strongly supported by most representatives of non-medical professions who predicted significant benefits, not only to their own ability to work closer to full scope of practice, but also for consumer access to care. Support among medical professionals was stronger among those who worked outside of metro settings, notwithstanding some notable risks and mitigations strategies.

Single payment rate for like services with a common scope (i.e. a single MBS rate for a particular activity)

There was some support for the consistent funding of activities and/or episodes of care that may be delivered by different health professionals (i.e. a single MBS rate for a particular activity), with some stakeholders noting improvements to interprofessional equity and an incentive to the delivery of specific activities by non-medical professionals. There was, however, some concern raised regarding the complexity of primary care consultations that are frequently not limited to a single activity and the risk of encouraging episodic care.

Technology

Participants broadly supported the concept of digital strategies to facilitate health professionals working to full scope of practice. However, it was frequently emphasised that technology enablement remains a tool to drive different aspects of the primary care system to work together more effectively or efficiently, rather than directly enabling full scope of practice.

Participants emphasised inequitable access due to system rules (where certain professions are blocked from accessing patient records), health literacy challenges, overreliance of telehealth models at the expense of face-to-face consultation or learning, and risk of privacy breaches. Overall, there was a view that strengthening existing patient data systems would itself mitigate risks around data quality and consistency. However, some suggested that technology solutions should not be wholly relied on due to the risk of outages or loss of access, particularly in rural and remote areas, and the need for backup systems to be in place.

The following potential areas for reform were proposed and feedback obtained through submissions and structured consultation.

Establishing access to real-time patient information

Establishing access to real-time patient information was supported nearly unanimously in principle, but significant reservations about its feasibility were voiced across consultation. Expanded access to My Health Record was strongly supported.

Introducing platforms for secure messaging and digital referrals

Introducing platforms for secure messaging and digital referrals was supported as a feasible means of enhancing visibility over other members of the care team and a key dependency for other policy proposals (such as expanded direct referrals and enabling multidisciplinary care teams), but participants warned against a proliferation of software which was seen as having little impact on practice.

Using decision support software

Decision support software was not broadly supported as a means of safely expanding scope of practice, compared to existing decision support tools, but was seen as a potential means of improving efficiency.

Mandating participation in a multidisciplinary care team for primary care providers

Mandating participation in a multidisciplinary care team for primary care providers was not strongly supported due to the mandate element, but most were supportive of the underlying principle achieved through other policy levers such as funding policy, education and training, and employer support.

Cross-cutting themes

During Phase 2 consultation, a series of additional factors outside of the five themes were identified as underpinning all policy areas. These cross-cutting themes can be summarised as follows:

Multidisciplinary care

The need to work together more effectively as multidisciplinary care teams was frequently identified, with the common view that this would enable a collective working to full scope (in addition to each individual team member working to their own full scope). This was described as critically important to strengthening the primary care system, which, in its current state, does not adequately support multidisciplinary team-based care for various reasons. Although stakeholders commended the intent behind efforts to strengthen multidisciplinary team-based care (such as through the Workforce Incentives Program), they also broadly expressed the

view that existing initiatives had not translated into widespread multidisciplinary practice because of continuing barriers, predominantly related to funding policy, legislation and regulation. There was significant support to build multidisciplinary teams around community and consumer need.

Stakeholders emphasised that, where workforce planning is typically approached by building teams based on professions and titles, a skills-based or scope-based approach was preferred, particularly in rural and remote areas. Establishing multidisciplinary care that is responsive to, and built around, the needs of the consumer, family and community, was viewed as better primary care, and a supported aim of reforms. Figure 3 depicts this aim.

Stakeholders discussed the intersections between the primary care system and adjacent systems, such as hospital, aged care and disability systems, many of whom are serviced by the same workforces. Care pathways between these systems were raised as being important to consider in terms of continuity of care.

Leadership, culture and governance

Leadership, culture and governance were described in all consultations as perhaps the most critical enabler (or conversely, barrier) to health professionals working to full scope of practice. Stakeholders discussed how these factors had a material impact on their ability to do all the things they are trained, qualified and competent to do, due to issues such as lack of interprofessional trust and understanding. Broader interprofessional issues at the leadership level, such as between professional organisations or jurisdictional governments, were also frequently raised as 'setting the tone' or overall culture in which health professionals do or do not work to full scope.

Leadership, culture and governance were seen as intersecting with all five policy themes in a bidirectional manner. Whilst legislation, regulation, funding policy, education and technology systems could have an influence on culture and leadership, there are elements of culture and leadership which are independent from these structures and more closely linked to (institutional) power, knowledge and trust. Stakeholders expressed that even if scope of practice were ostensibly fully enabled by these mechanisms, health professionals' practical ability to work to full scope of practice would remain limited without a corresponding cultural shift from primary care system leadership.

This issue was discussed particularly as it relates to the perceived power imbalance between self-regulated professions, regulated professions and those regulated outside of these two mechanisms. Many stakeholders representing self-regulated professions expressed concerns about a primary care system culture that perceives self-regulated professions as less competent or delivering less value than regulated professions. Likewise, there was frequent discussion about the need to recognise the essential role that professions regulated outside of the NRAS or self-regulation, such as the support workforce, play in maintaining an effective primary care system (particularly due to the inherent links between this workforce, aged care and disability), whilst recognising the boundaries of their scope of practice. Meanwhile, many GPs were clear that general practice should be respected as a specialist discipline alongside other medical specialties, and valued and remunerated as such. A broad consensus was reached that each primary care health professional plays a critical role in the health system, and that it is therefore important that their scope of practice is fully understood, valued and enabled.

Phase 2 of the Review provided large amounts of information, gathered through consultation and the literature and evidence review. Together, these sources of information informed the next two phases of the Review, which are described in *Section 4. The case for change.*