



Unleashing the Potential of our Health Workforce

Scope of Practice Review

Extract of 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.

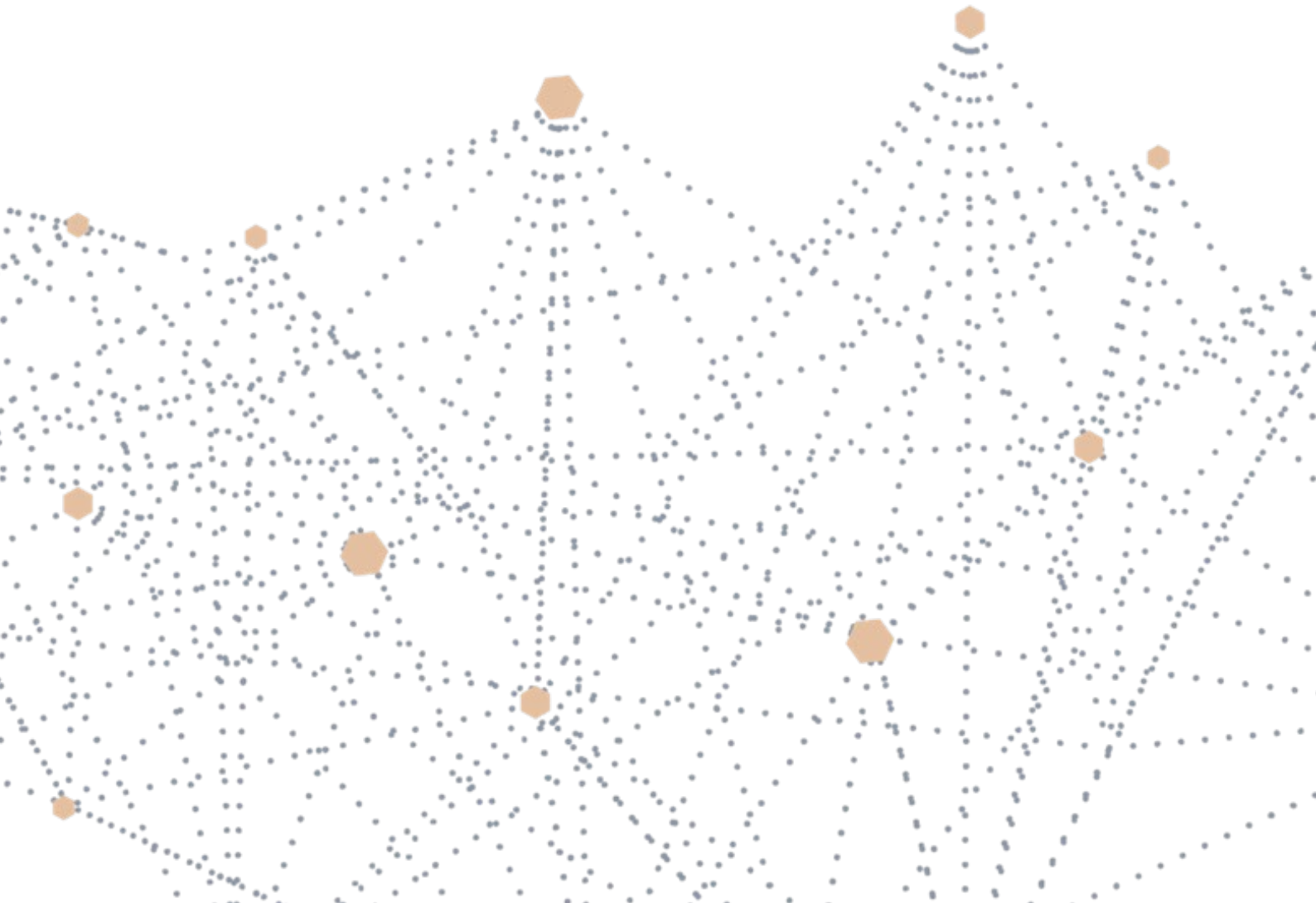
Practice standards, professional standards	Define the practice and behaviour of a health professional and may include codes of conduct, standards of practice, codes of ethics, as well as competency and professional capabilities.
Primary care	Primary care is a model of care that supports first-contact, 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.

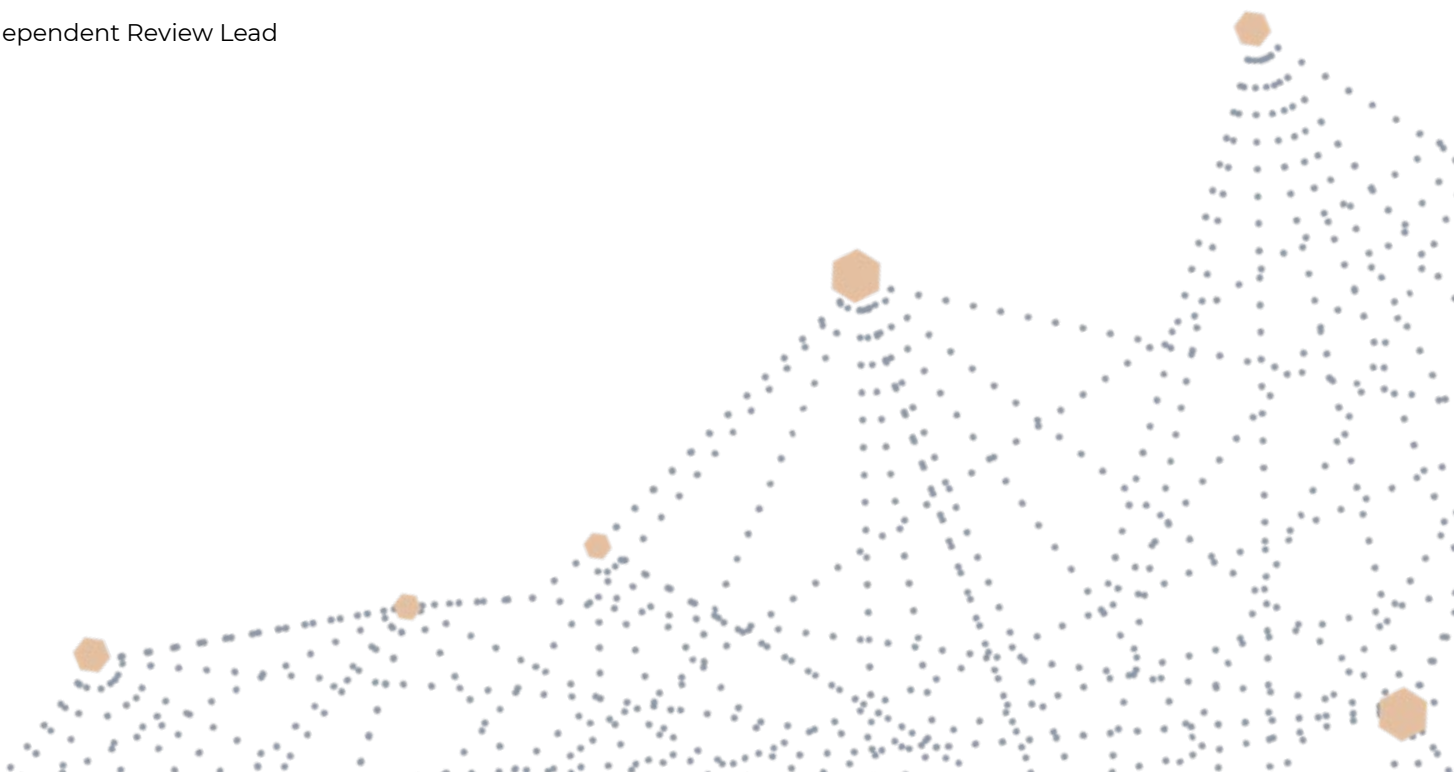
I am proud to have led this Independent Review and would like to take this opportunity to express my sincere gratitude to all those who contributed to the consultation sessions and provided valuable feedback, with special thanks to the Expert Advisory Committee convened to support this Review.

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:

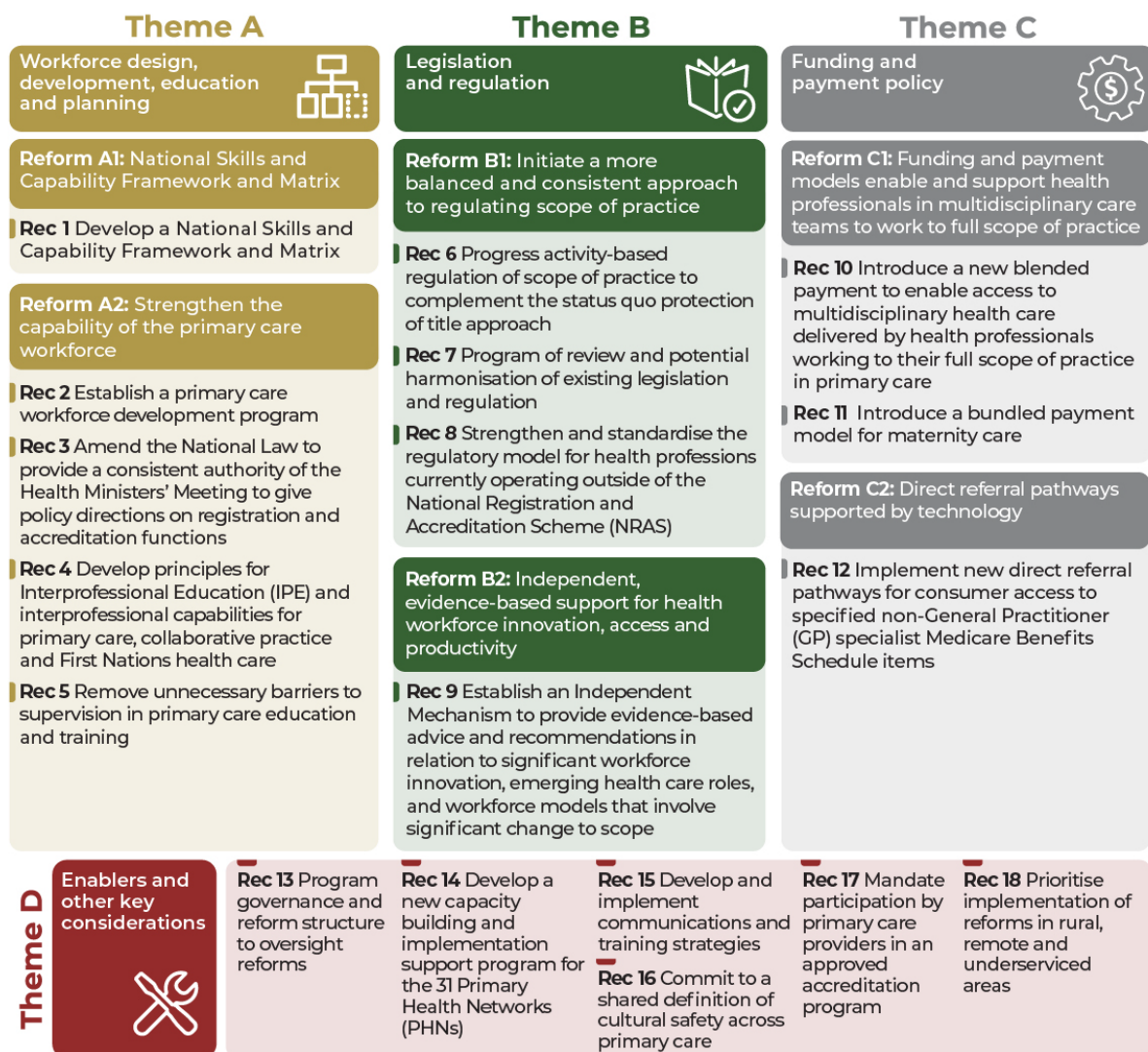
- **There is limited awareness of health professional scope of practice across the multidisciplinary primary care team.** Consumers and health professionals frequently have a limited understanding of the scope of practice (skills, knowledge, competence and authorisation) of members of the primary care 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 2020-2025².

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.

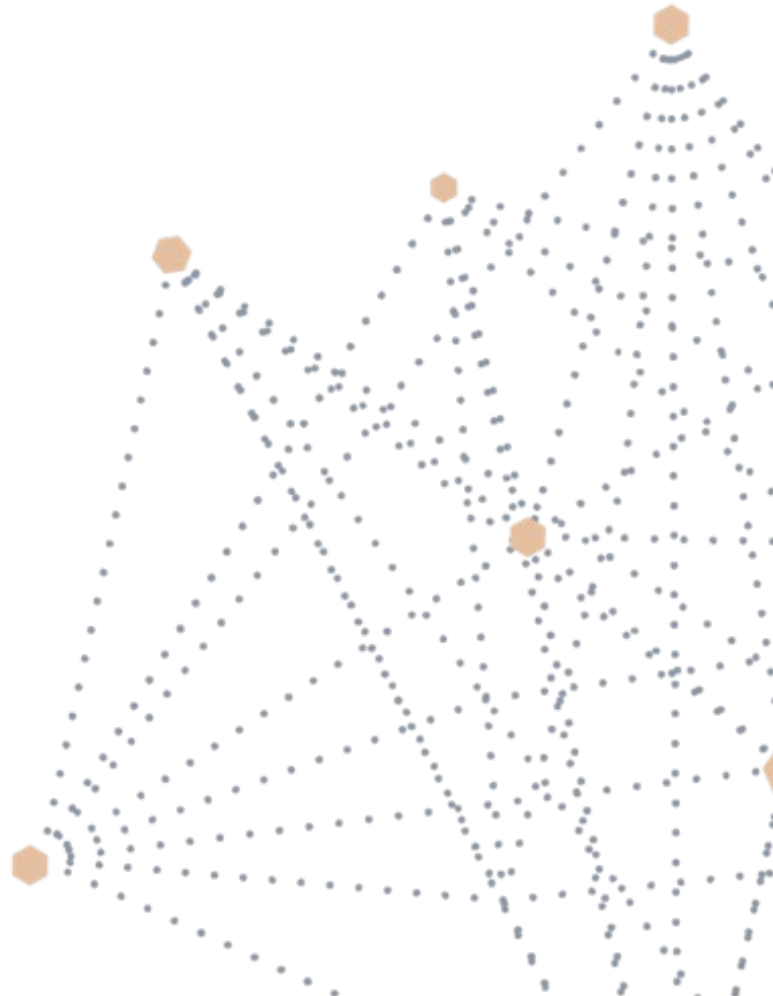
- 1.1** Establish an independent, national mechanism, reporting through to Health Ministers to create, maintain, develop and promote the Matrix. This may be incorporated as part of Recommendation 9.
- 1.2** Implement an ongoing program of education, promotion and adoption of the Matrix to support awareness 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.

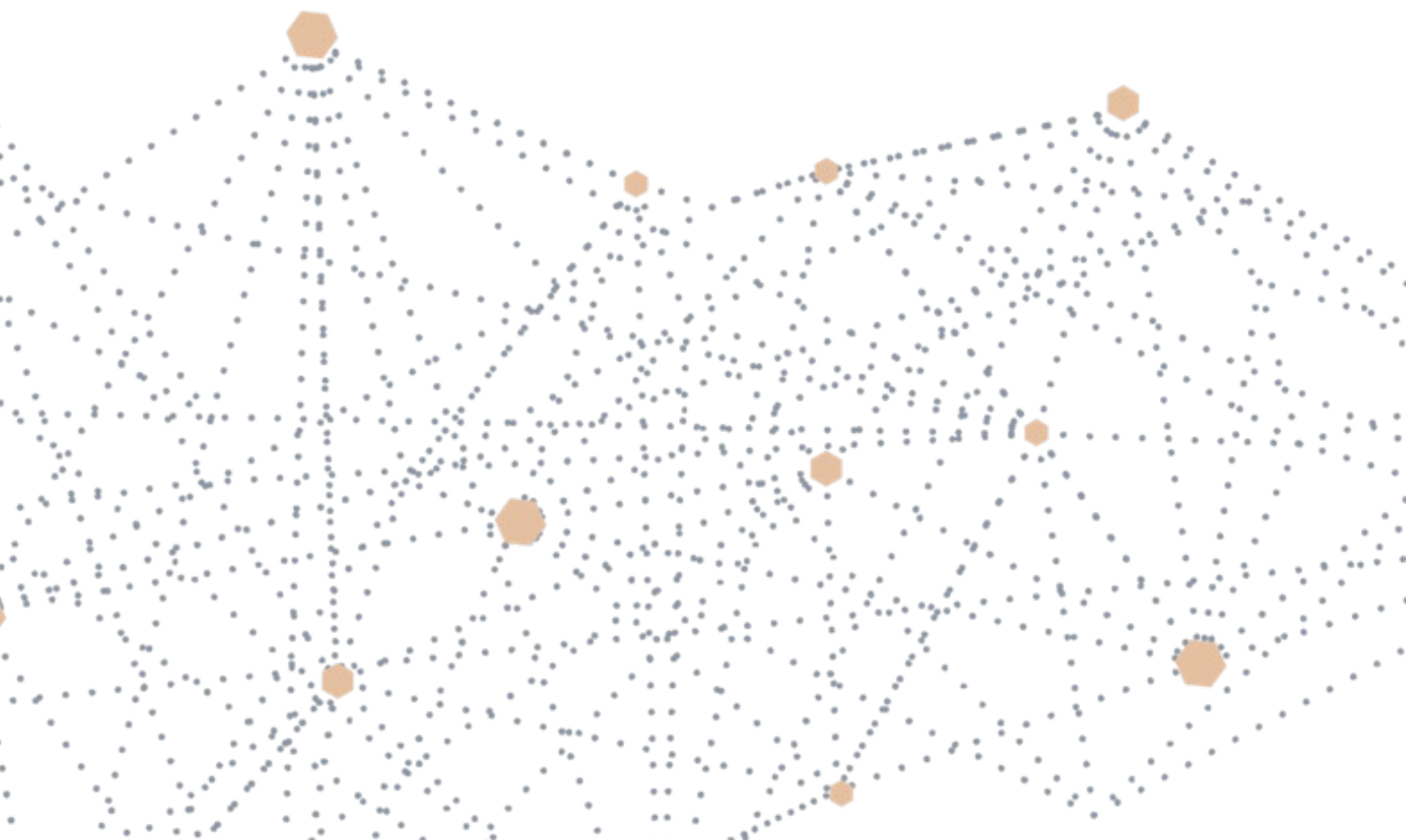
The Matrix will also inform health workforce design, planning, and development, enabling consumers to access timely care, provided as close to home as possible. This will be particularly useful for workforces in rural, remote and underserved areas.

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:

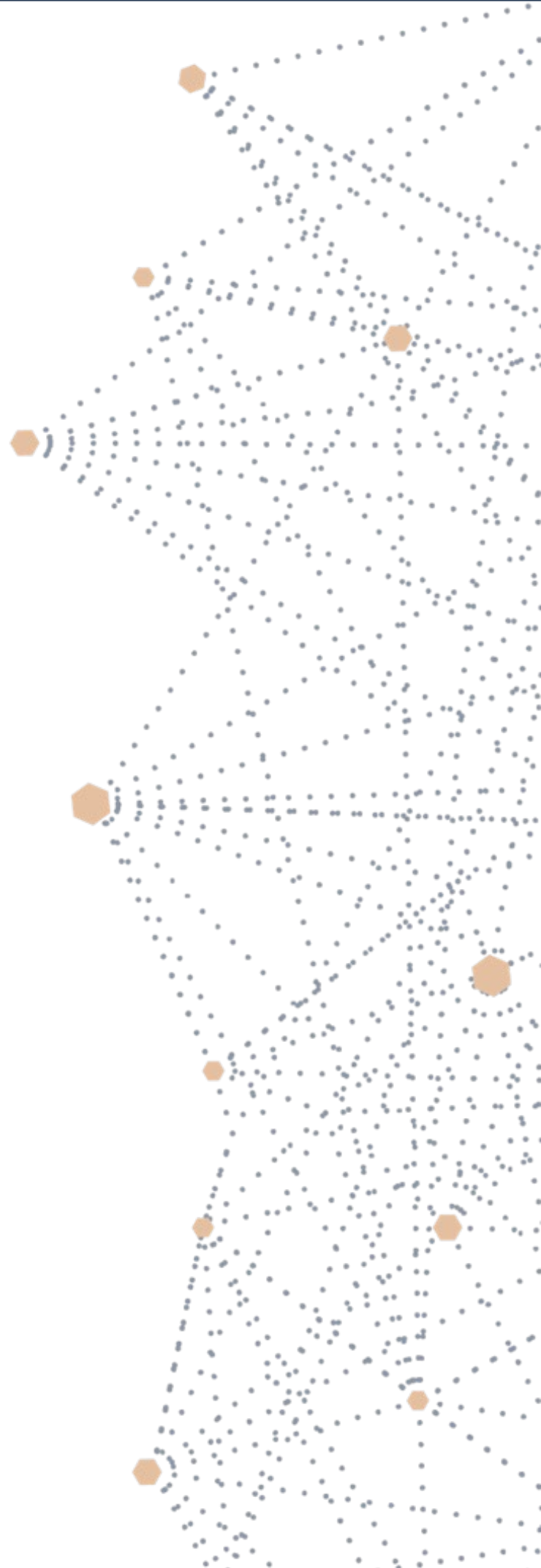
For the consumer

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

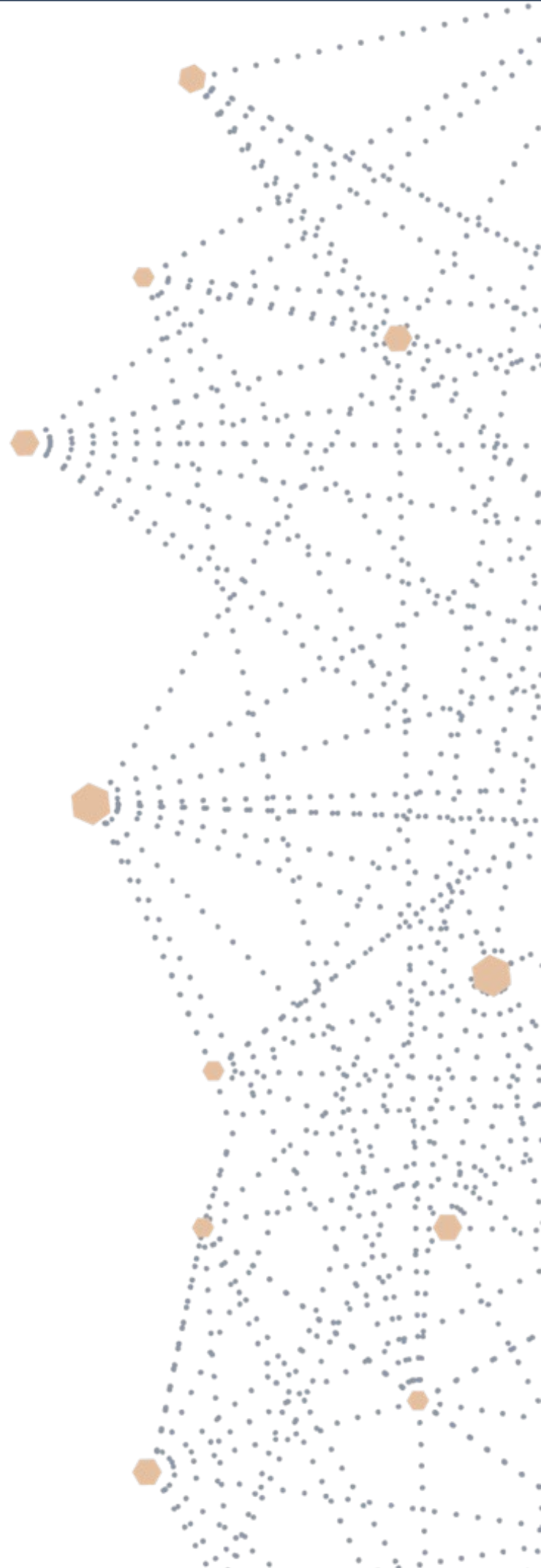
Students benefit from an alternative professional view of care and a broadened understanding of the primary care health system. Cross-professional supervision may also support training experiences that would otherwise not be possible.

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.

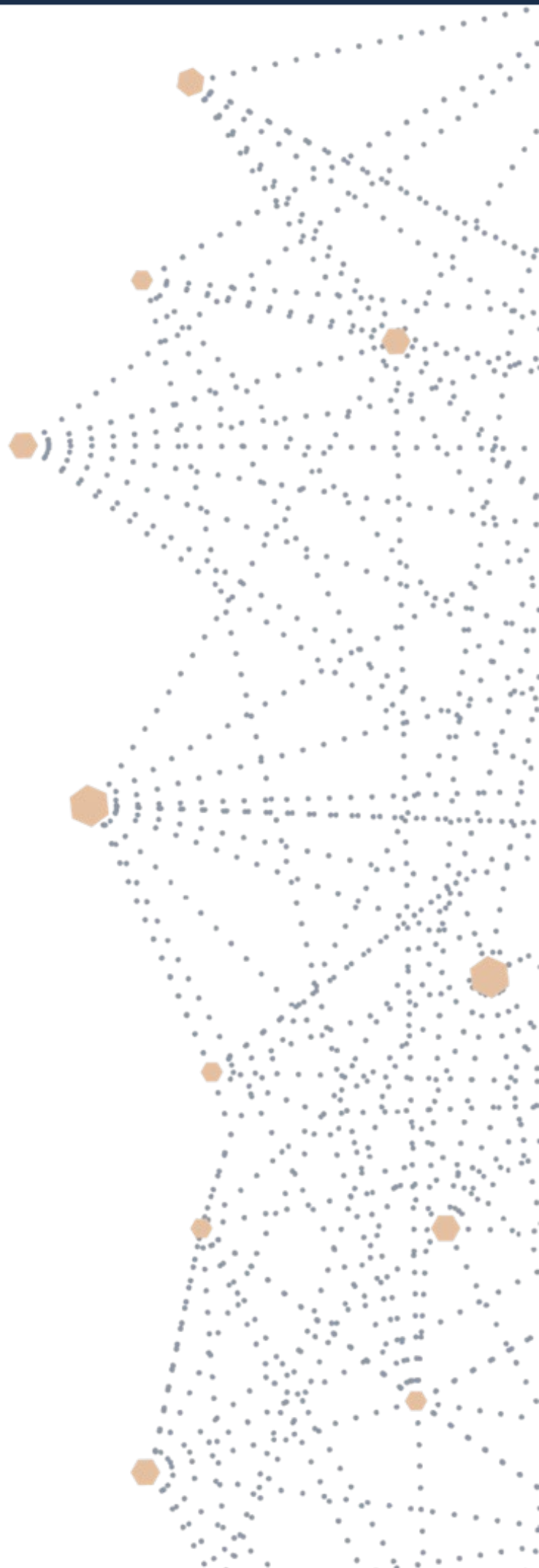
Intended outcome of the recommendation

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.

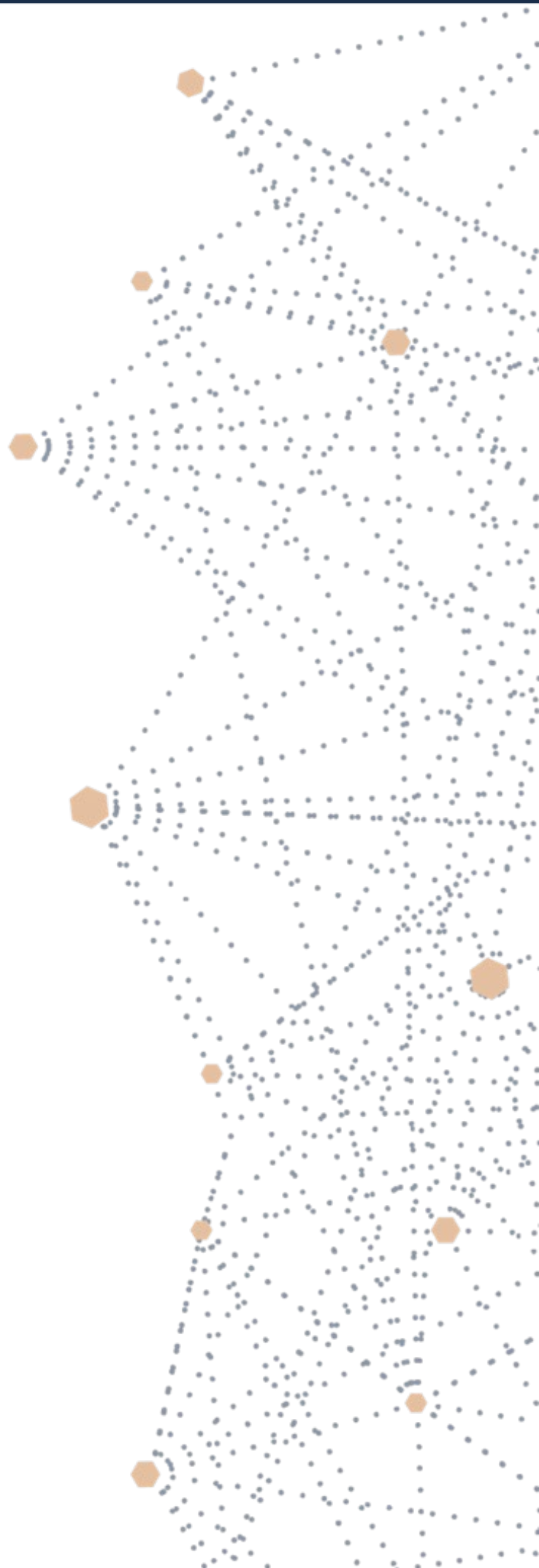
Intended outcome of the recommendation

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 underserved 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 underserved 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)
- Underserved regional and outer metropolitan areas
- Other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserved 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 practices³ 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 conservative 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 underserved 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 underserved 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.












Implementation roadmap

This section provides a high-level roadmap which 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 1 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. 
	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. 
	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. 
	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 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. 
	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. 
Medium-term	1.1 Establish an independent, national mechanism, reporting through to Health Ministers to create, maintain, develop and promote the Matrix. 
	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. 
	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. 
	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 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. 
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. 
	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. 

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|---|---|--|
|  Health Ministers' Meeting (HMM) responsibility |  Accreditation Authorities responsibility |  Independent Mechanism responsibility |
|  Australian Government responsibility |  State and territories responsibility |  Dependent on HMM decision |
|  National Boards/Professional Organisations responsibility |  Higher education providers responsibility |  Ongoing |

Theme B: Legislation and regulation

Short-term	<p>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].</p>	G S/T
	<p>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. <i>shorthand references</i> - and instead adopt an approach based on assessment and management of the inherent risk associated with the activity being regulated or restricted.</p>	G S/T
	<p>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.</p>	H B
	<p>7. Health Ministers agree to a program of review and potential harmonisation of existing legislation and regulation which contain unnecessarily restrictive application of <i>shorthand references</i>, 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.</p>	G S/T
	<p>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.</p>	H
Medium-term	<p>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.</p>	DH G S/T
	<p>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:</p> <p>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</p> <p>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'</p> <p>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.</p>	H
	<p>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.</p>	H
	<p>9.1 Independent Mechanism to hold responsibility for developing the National Skills and Capability Framework and Matrix (Recommendation 1) as a priority initial activity.</p>	I

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|--|--|---|
| 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 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 underserved 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), underserved regional and outer metropolitan areas, and other metropolitan areas based on demonstrated capacity of providers and higher relative need of underserved 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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| 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 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 underserved areas, and to engage with relevant organisations and stakeholders to collaboratively design implementation solutions specific to rural, remote and underserved 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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|--|--|---|
| 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 |



Conclusion

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.

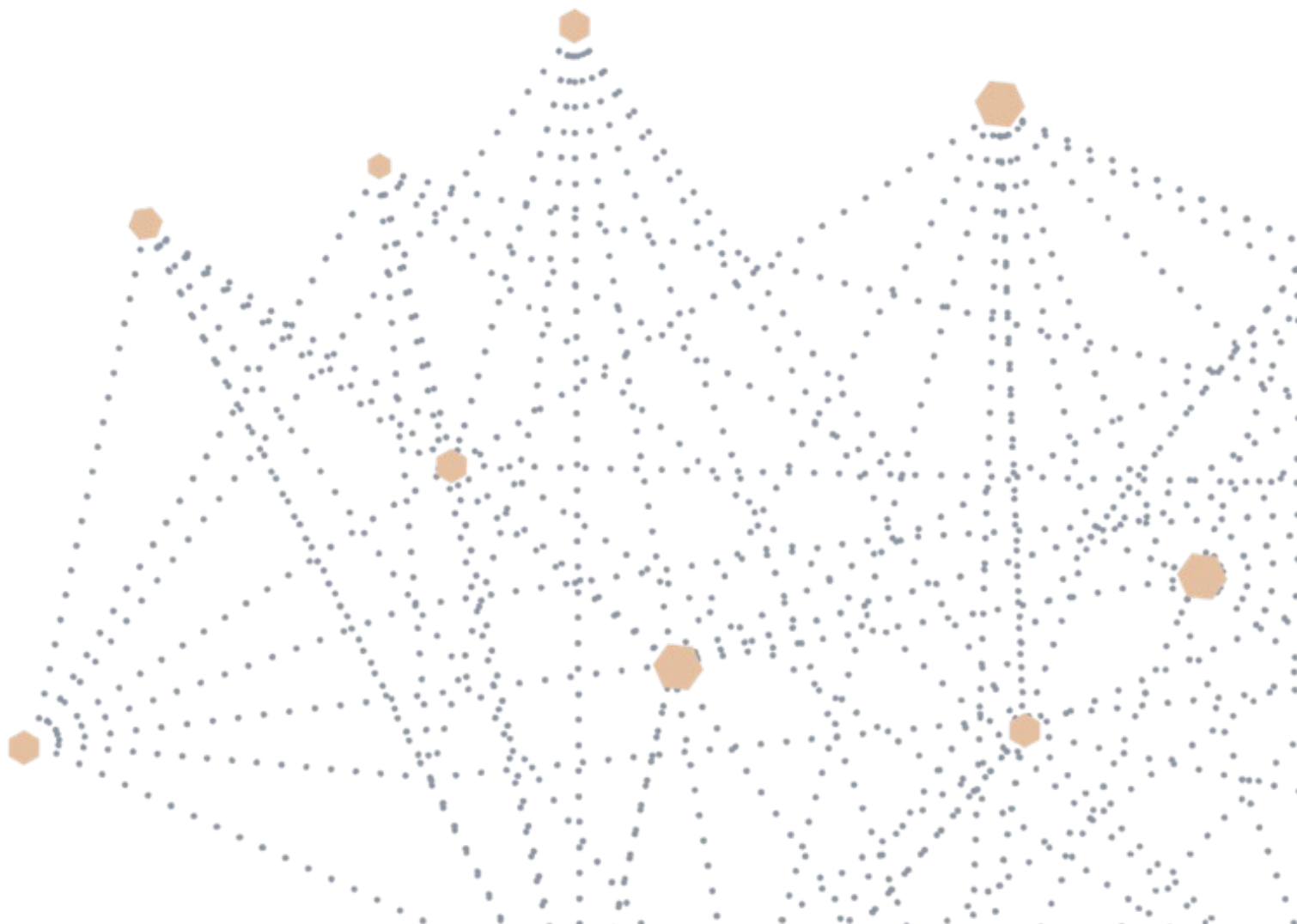
Many professions have individually faced, and addressed (or attempted to address), the issues identified in this report. Enacting change that enables health professions to work to full scope of practice provides learning opportunities for the entire health system. However, these opportunities have largely 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.^{4,5,6} Particularly in rural and remote communities, the role of the community paramedic may address workforce issues.⁷ 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.⁸ 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.

⁴ 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>

⁵ 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.

⁶ 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>

⁷ Ibid.

⁸ 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.^{9,10,11} 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 2020-2025.¹²

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.

⁹ 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.collegn.2023.05.004>

¹⁰ 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>

¹¹ 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>

¹² 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.¹³ 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**).

¹³ 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.

Acknowledgements

The Independent Review Lead would like to acknowledge the significant contributions made by the following individuals:

University of Queensland Centre for the Business and Economics of Health

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 Amanda Griffiths
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 Vanessa Van Der Zwart
 Alex Jones
 Kerri Kellett
 Alana Pekar
 Toby O'Brien
 Megan McCarthy
 Michelle Yim
 Gerard Wilton
 Angela Cummings
 Susan Greenaway

And special thanks to

Professor James Buchan
 Professor Stephen Duckett
 Dr Steve Hambleton
 Dr Walid Jammal
 Scott Sutherland

