

Unleashing the Potential of our Health Workforce

Scope of Practice Review

Stakeholder Engagement Report 1

27 March 2024

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1 Executive summary

This report summarises key insights from Phase 2 stakeholder consultation undertaken as part of the Unleashing the Potential of our Health Workforce Review (the 'Scope of Practice Review'), hereafter 'the Review'. A process of public consultation was undertaken in January to March 2024, consisting of:

- A program of in-person round table consultations across all capital cities and Launceston (486 participants across 19 consultation sessions), held from 6 February to 27 February 2024
- Targeted online consultation with rural and remote stakeholders (51 participants across two virtual consultations), held on 4 March 2024
- An online survey published on the Citizen Space platform, open between 23 January 2024 and 8 March 2024 (receiving 161 written submissions)
- Receipt of email submissions (75 received at time of preparing this report)

In both consultations (in-person and online) and the Citizen Space survey, stakeholders were asked to respond to questions about five theme areas corresponding to themes identified in Issues Paper 1. In addition, participants were asked to assess the merits of proposed policy options put forwards in that paper. Participants in the online survey were invited to respond to a total of 19 questions across the five themes, adapted for an online context.

A wide range of stakeholders including health professionals, employers, payers, governments and consumers attended the consultations and provided written submissions, the majority representing health professions (practicing and/or representing professional organisations and peak bodies). Further consultation is being pursued to strengthen the representation of consumer and First Nations perspectives, and will be considered in future reporting as part of this Review.

Stakeholder views were examined for the relative level of support presented across each of the proposed policy solutions; key areas of convergence, divergence and interdependency; and any emerging themes or policy solutions which did not appear in Issues Paper 1. This report summarises the major themes extracted from the survey, submissions and face-to-face consultations.

1.1 Summary of key findings

The table below consolidates key findings against each of the policy solutions explored in Issues Paper 1, as well as emerging and cross-cutting themes. Note that use of the terms 'stakeholders' and 'participants' throughout refers to people who participated in the consultations, provided a response via email and/or completed the survey via Citizen Space.

Table 1: Summary of Stakeholder Engagement Report themes

Theme	Key Finding	Description
Cross-cutting theme	Multidisciplinary care	Strong support for multidisciplinary care teams built around community needs, using a skills-based workforce planning approach. There was disagreement about who stakeholders thought should lead the team.
Cross-cutting theme	Leadership, culture and governance	These were seen to interact with all other themes, acting as a critical barrier or enabler to full scope of practice, while also potentially being influenced by other policy solutions. Challenges in leadership, culture and governance were often linked to power imbalances (actual or perceived).
Legislation and regulation	Harmonising Drugs and Poisons legislation	This policy option was overall seen as a highly impactful reform with potential to significantly improve health professionals' ability to work to their full scope, and to do so consistently across jurisdictions.
Legislation and regulation	Introducing risk-based and activity-based regulatory processes	This policy solution was overall seen as having the potential to significantly impact health professionals' ability to work to their full scope, albeit with some potential risks which would require careful consideration in how this solution were to be implemented.
Legislation and regulation	Reviewing authorising environments in self-regulated professions and the unregulated workforce	There was broad agreement that authorising environments in self-regulating professions were preventing full scope of practice, particularly embedded in legislation that referred in shorthand to the National Law. Consensus was not reached on whether bringing additional professions under NRAS would positively or negatively impact self-regulated professions.
Legislation and regulation	Streamlining endorsement processes	This policy solution was mainly a priority for those professions directly affected by rules perceived as arbitrary or inconsistent, and could have the potential to significantly impact these professionals' ability to work to their full scope of practice.

Theme	Key Finding	Description
Legislation and regulation	Additional perspectives	<ul style="list-style-type: none"> Medical indemnity insurance: risks raised that indemnity providers may not cover all aspects of scope Reform to regulation restricting practice of certain groups: overseas trained health professionals and people returning to work after a career break experience barriers to working to their full scope
Employer practices and settings	Establishing models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers	Participants were highly supportive of multidisciplinary care models. Improvements in interprofessional trust, understanding and respect, alongside improved consumer experiences of care and health outcomes, were commonly viewed as key potential impacts of this policy solution.
Employer practices and settings	Establishing more consistent approaches to recognition of qualifications and competencies across settings	This policy option was viewed as supporting clarity regarding the potential contribution of individual professions to the primary care team and to an improved overall functioning of the team.
Employer practices and settings	Reviewing clinical governance mechanisms in primary health care settings	Supporting primary care providers through clear governance mechanisms was viewed as providing structural strength for the primary health care team and significant patient safety assurances.
Employer practices and settings	Additional perspectives	<p>Employer contribution to optimal team-based care: through remuneration, skill recognition, clear practice standards, policies and procedures, quality assurance and cultural influence</p> <p>Culture and equity: need for equal recognition and valuing of all health professions, and a broader view of the health workforce</p> <p>Industrial considerations: the need for a range of provisions to be included in approaches to industrial agreements.</p>

Theme	Key Finding	Description
Education and training	Establishing greater system-wide clarity about requirements of post-entry learning	In addition to promoting a greater appreciation of health professional skill, this policy area was linked to workforce mobility, flexibility and responsiveness, noting that employment opportunities across jurisdictions may be more attractive where qualifications are readily recognised. Stakeholders highlighted the need for skill recognition to be linked to appropriate remuneration.
Education and training	Establishing a nationally consistent approach in promoting and implementing common interprofessional competencies	This was widely supported as contributing to a strong primary care team that understands and respects the contribution of each profession and has the skills to work cohesively to meet consumer and community need.
Education and training	Ensuring ongoing education and training are accessible	Ensuring access to continued education opportunities was viewed as an important mechanism to support the individual to maintain and advance their skills and the primary care team to achieve its optimal capacity.
Education and training	Additional perspectives	<ul style="list-style-type: none"> • Supervised practical training: clear view that learning undertaken in the practice setting provides a context-rich experience for the learner and should be encouraged in educational programs. • Recognition of early career professionals' full capabilities: Supervision and/or mentorship were frequently highlighted as essential (but often lacking) supports in early career. • Recognition and utilisation of the generalist practitioner and primary care: importance of funded programs that develop generalist skills and exposure to primary care in all health professions • Importance of the para-professional workforce: national recognition and consistent education are important for this workforce.

Theme	Key Finding	Description
Funding policy	Using block, bundled and blended funding to deliver care flexibly	There was strong support for a range of alternative funding mechanisms, particularly those that contained a block funding component, as a complement to fee-for-service payments which were broadly seen as restricting scope.
Funding policy	Funding and payment types which incentivise working as multidisciplinary care teams	Participants expressed strong support for the principle of multidisciplinary care teams, and raised a number of potential funding models they saw as incentivising team-based care, particularly payment for advice or care coordination.
Funding policy	Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules	This policy proposal was strongly supported by most representatives of non-medical professions who predicted significant benefits not only to their own ability to work closer to full scope of practice, but also for consumers in terms of access. Support among medical professionals was stronger among those who worked outside of metro settings, notwithstanding some notable risks and mitigations strategies.
Funding policy	Funding episodes of care regardless of profession (i.e. a single MBS rate for a particular activity)	There was overall strong support for this policy proposal particularly among non-medical professions, with hesitation from some representatives of the medical profession on the basis it may potentially reemphasise episodic care to the detriment of the consumer.
Funding policy	Additional perspectives	<ul style="list-style-type: none"> • Private health insurance: recognised need to work with private health insurance providers to ensure scope of practice adequately reflected in policies. • Equalising access to MBS billing and PBS prescribing: expanding MBS and PBS access to additional professionals/episodes of care could address identified practice barriers in using fee-for-service.

Theme	Key Finding	Description
Technology	Establishing access to real-time patient information	This policy proposal was supported nearly unanimously in principle, but significant reservations about its feasibility were voiced across consultation. Expanded access to My Health Record was strongly supported.
Technology	Introducing platforms for secure messaging and digital referrals	This policy solution was supported as a more feasible means of enhancing visibility over other members of the care team and a key dependency for other policy proposals (such as expanded direct referrals and incentivising multidisciplinary care teams), but participants warned against a proliferation of software which was seen as having little impact on practice.
Technology	Using decision support software	This policy solution was not broadly supported as a means of safely expanding scope of practice, compared to existing decision support tools, but was seen as a potential means of improving efficiency.
Technology	Mandating participation in a multidisciplinary care team for primary care providers	This policy solution was not strongly supported due to the mandate element, but most were supportive of the underlying principle albeit achieved through other policy levers such as funding policy, education and training, and employer support.
Technology	Additional perspectives	<ul style="list-style-type: none"> • Telehealth: useful for increasing access to training, supervision and care teams, but some concerns about overreliance on telehealth. • Artificial intelligence: hesitancy about its risks in relation to scope of practice, but a potential means of reducing administrative burden (and indirectly increasing ability to work to full scope)

2 Introduction

2.1 Background

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

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

In December 2022, the Strengthening Medicare Taskforce Report outlined the Strengthening Medicare Taskforce's priority recommendations to improve primary care. One of these was that the Australian Government work together with states and territories to review the barriers and incentives for all health practitioners to work to their full scope of practice.

In April 2023, National Cabinet, which consists of the Prime Minister and first ministers from all states and territories, supported the Taskforce recommendation. In response, the 2023-24 Budget provided funding to conduct a review of health professions scope of practice.

Professor Mark Cormack is leading this intensive, independent review. Titled *Unleashing the Potential of our Health Workforce, the Scope of Practice Review*, the review is being conducted in four phases between September 2023 and October 2024. The current period of consultation forms part of Phase Two of the review. The review focuses on the following health professions:

- general practitioners (GPs)
- nurses, including nurse practitioners, registered nurses and enrolled nurses
- pharmacists
- midwives
- allied health practitioners
- Aboriginal and Torres Strait Islander Health Practitioners and Health Workers
- paramedics
- support and assistance workforces.

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

The review is expected to submit its findings, including recommendations and an implementation plan, to the Australian Government by the end of 2024.

2.2 Phase Two consultation

The Review seeks to gather broad consultation over the four phases to hear and consider all perspectives and voices. During Phase One of the review, public consultation yielded in

excess of 700 submissions from a wide range of stakeholders. The findings of this consultation were provided in the first Issues Paper.

This report summarises the second round of public consultation conducted during Phase Two of the review. Consultation was conducted between 23 January 2024 and 8 March 2024. Stakeholders provided their views using the following mechanisms:

- A program of in-person round table consultations across all capital cities and Launceston (486 participants across 19 consultation sessions), held from 6 February to 27 February 2024
- Targeted online consultation with rural and remote stakeholders (51 participants across two virtual consultations), held on 4 March 2024
- An online survey published on the Citizen Space platform, open between 23 January 2024 and 8 March 2024 (receiving 161 written submissions)
- Receipt of email submissions (75 received at time of preparing this report)

Collectively, these inputs provide stakeholder perspectives on five key areas relating to health professional scope of practice:

- Legislation and Regulation
- Funding
- Employer Practices
- Education and Training
- Technology

2.3 Purpose of this document

This paper summarises the major themes identified in the submissions received during Phase Two consultation, including:

- written submissions received in response to an online survey hosted on the Citizen Space platform
- written submissions received via email in response to the Scope of Practice Review request for submission
- consultation notes from the stakeholder consultations undertaken by the IRL team.

The analysis builds on the consultation findings obtained during the first phase of the Review. Together with the findings of a concurrent literature review and legislation and regulation review, the analysis will contribute to the development of a second Issues Paper, which will be available for further consultation and feedback.

3 Approach

3.1 Methodology

Consistent with the overarching objectives of the Review, stakeholder consultation is critical to the development of meaningful outcomes. To ensure a breadth of perspectives were harnessed, feedback on the first Issues Paper was sought using three mechanisms as outlined in 2.3 *Purpose of this document*. Analysis of the consultation responses was undertaken using an iterative process to identify common themes and illustrative examples.

In-person and virtual consultation sessions involved group discussions in response to semi-structured questions posed by experienced facilitators. Sessions were recorded manually by dedicated support personnel. Where possible, verbatim recording of conversations was undertaken. At the conclusion of each session, the facilitator and support team member discussed the recorded notes to clarify and confirm key findings and identify common themes. Recorded notes were independently reviewed by two members of the Review team to determine alignment with identified themes. Additional themes and context-relevant examples were added at subsequent consultation sessions.

Written submissions were sought through an online survey on the Citizen Space platform, for which consultation questions identified in Issues Paper 1 were adapted for an online context. Stakeholders were also directed to submit written submissions in a format of their choosing to the Scope of Practice email account.

Written submissions received in response to the survey questions and via email were reviewed for alignment or divergence from the themes identified during in-person/virtual consultation sessions. Additional themes and/or examples were added to augment the findings previously identified. Quantitative analysis of the survey was conducted.

3.2 Limitations

An error in the online survey mechanism designed to collect demographic information (health professional group, State or Territory, Modified Monash Method classification and First Nations identification) means that no demographic data in these categories was collected for online survey responses. This limits the interpretability of the survey responses particularly from a First Nations perspective.

The analytical approach applied to the unstructured free text could be subject to researcher bias, i.e. potential oversight or overstatement of themes or missed nuances. An independent review process was undertaken to attempt to minimise this bias and maximise reliability of analysis.

Another potential limitation lies in respondent bias, given that this study relied on a subset of individuals who voluntarily participated in consultation sessions, online surveys, or submitted written responses. This could introduce a bias toward particular opinions or predispositions within this group compared to the broader sample of interest, potentially leading to the amplification (or otherwise) of certain perspectives or themes.

It is noted this analysis forms one input to a larger program of extensive stakeholder engagement, which will seek to counteract these limitations, and will inform future parts of

the Review. Notably, further consultation is being pursued to strengthen the representation of consumer and First Nations perspectives, and will be considered in future reporting as part of this Review.

3.3 Note on terminology

Note that use of the terms 'stakeholders' and 'participants' throughout this document refers to people who participated in the consultations, provided a response via email and/or completed the survey via Citizen Space.

Aligning with the approach taken in previous reports compiled as part of this review, this report refers to 'full scope of practice' to encompass a range of terms used by participants including 'full', 'top of', 'extended', 'expanded' and 'advanced' scope.

4 Overview of stakeholder consultation

Overview of in-person and virtual consultations

Twenty-one face-to-face consultation sessions were conducted (19 in-person, 2 virtual) between 7 February 2024 and 4 March 2024. The Review team visited all state and territory capital cities and Launceston during the consultation period.

A total of 486 stakeholders participated in the in-person consultations, including health consumers, health professionals, professional organisations, peak bodies, educators, government, regulators, insurers, employers, funders and unions. A range of professions were represented, including nursing and nurse practitioners, general practice, pharmacy, midwifery, allied health, paramedicine and Aboriginal and Torres Strait Islander Health Practitioners and Health Workers. A further 51 participants participated across two virtual consultations, which targeted rural and remote stakeholders.

A summary of in-person and virtual consultations is provided in Appendix A.

Overview of written submissions

A total of 161 survey responses were received through the Citizen Space platform between 23 January 2024 and 8 March 2024. Participants were asked a total of 19 questions across the five themes. Response rates for each question are provided in Appendix B. The majority of responses (51%) were received from individuals who identified themselves as health professionals.

Stakeholders were also invited to provide written submissions via email. 75 written submissions received were via email up to a deadline of 12 March 2024, provided on 13 March 2024. These written submissions were provided in a range of formats such as position papers, external reports and other attachments the respondent wished to be considered in the Review.

An additional 35 written submissions were provided after 13 March 2024 per extensions granted on request. These written submissions are not reflected in the report but will be reviewed and the input considered in the development of Issues Paper 2 and the Final Report.

5 Findings and stakeholder themes

5.1 Summary of cross-cutting findings

5.1.1 Multidisciplinary care

Much of the discussion in consultations centred on the need to work together more effectively as multidisciplinary care teams, and that doing this would enable a collective working to full scope (in addition to each individual team member working to their own full scope). This was described as critically important to strengthening the primary health care system, which in its current state does not adequately support multidisciplinary team-based care for various reasons. Although stakeholders commended the intent behind efforts to strengthen multidisciplinary team-based care (such as through the Workforce Incentives Program), they also broadly expressed that existing initiatives had not translated into widespread multidisciplinary practice because of continuing barriers, predominantly related to funding policy, legislation and regulation. Across all themes, policy solutions which introduced targeted strategies to facilitate more multidisciplinary team-based care were overall supported, both for their intent and the practical solutions they offered to problems experienced in practice.

Stakeholders held various views about how they perceived the multidisciplinary care team to be structured, corresponding to the actual variation in these models in practice. Many GPs and other health professionals described the benefits of having multiple disciplines working together under one roof, under the assumed leadership or guidance of the GP (GP-led or GP-supported multidisciplinary health teams). However, other stakeholders, particularly representing regional and remote communities, held a broader view of multidisciplinary care teams as working together across different services and highlighted that this is standard practice in many areas where relationship-building between professionals is a critical part of delivering safe primary health care. These views carry implications for the importance of this Review in acknowledging and supporting different types of multidisciplinary care teams working together, and maximising flexibility to allow this.

Moreover, across a notable proportion of consultations there was significant discussion of the need to build multidisciplinary teams around community and consumer need, as summarised by one participant:

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

Participants emphasised that whereas workforce planning is typically approached by building teams based on professions and titles, a skills-based or scope-based approach was preferred, particularly in rural and remote areas as summarised by one participant from the Northern Territory:

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

Following the preferred skills- or scope-based approach was seen as a key opportunity to develop care teams with the requisite skills and authorisation to deliver the right range of services to the community based on its specific and identified needs. The disconnect between workforce planning approaches and required scope was perceived as particularly significant in rural and remote areas, given workforce constraints and reliance on fly-in-fly-out workers. Participants from these regions emphasised the need for more proactive workforce planning to take place which builds scope around community needs.

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

5.1.2 Leadership, culture and governance

Leadership, culture and governance were described in all consultations as perhaps the most critical enabler (or conversely, barrier) to health professionals working to full scope of practice. Stakeholders discussed how these factors had a material impact on their ability to do all the things they are trained, qualified and competent to do, due to issues such as lack of interprofessional trust and understanding. Broader interprofessional issues at the leadership level, such as between professional organisations or jurisdictional governments, were also frequently raised as 'setting the tone' or overall culture in which health professionals do or do not work to full scope.

Leadership, culture and governance were seen as intersecting with all five policy themes in a bidirectional manner. Whilst legislation, regulation, funding policy, education and technology systems could have an influence on culture and leadership, there are elements of culture and leadership which are independent from these structures and more closely linked to (institutional) power, knowledge and trust. Stakeholders expressed doubt that even if scope of practice were ostensibly fully enabled by these mechanisms, health professionals' practical ability to work to full scope of practice would remain limited without a corresponding cultural shift from primary health system leadership.

This issue was discussed particularly as it relates to the perceived power imbalance between self-regulated, unregulated and regulated professions. Many stakeholders representing self-regulated professions expressed concerns about a primary health system culture that perceives self-regulated professions as less competent or serving less value than regulated professions. Likewise, there was frequent discussion about the need to recognise the essential role that unregulated professions, such as the support workforce, play in maintaining an effective primary health system (particularly due to the inherent links between this workforce, aged care and disability), whilst recognising the boundaries of their scope of practice. Meanwhile, many GPs were outspoken in their opinion that general practice should be considered a specialisation alongside other medical specialties, and valued and remunerated as such. A broad consensus was reached that each primary health professional plays a critical role in the health system, and that it is therefore important that their scope of practice is fully understood, valued and enabled.

5.1.3 Impacts of barriers to full scope of practice

Stakeholders discussed a wide range of actual and potential impacts of circumstances where primary health care professionals are prevented from working to their full scope of practice. Most, if not all, of the policy solutions discussed were designed to address these impacts in some way. The impacts described by stakeholders were relatively consistent across themes, and include:

- **Workforce mobility** – primary health care professionals are restricted from working across different settings, services, or jurisdictions because they would lose the ability to perform aspects of their scope, or because they would need to undertake additional training at their own time or expense to continue to work at their full scope of practice.
- **Workforce retention** – significant and repeated barriers to working to full scope of practice may influence people to leave their profession. One example was given of a paramedic who, upon encountering significant barriers to their ability to act as a locum community paramedic across different states and territories, chose to retire early and left the profession.
- **Consumer access** – numerous instances were described where limitations to scope of practice caused consumers to have to repeatedly see health professionals. In particular, it was emphasised that while these issues present an inconvenience to people living in metropolitan areas (or at worst, a safety risk), in regional and remote areas they frequently serve as a barrier to receiving care altogether. If a consumer requires a particular service from a particular health professional who does not exist within a region they can practically travel to, they are effectively prevented from receiving that service. For instance, one participant gave a Victorian example where pharmacists working in regional Urgent Care Centres are prevented from supplying medicines unless there is a medical practitioner on the premises, despite the fact that most weekend and after hours urgent care is provided by nurses in this setting. Consumers are therefore prevented from being supplied medicines when medical practitioners are not present.
- **Burden on general practice workforce** – participants discussed how the limitation of activities, such as referral and prescribing, to GPs resulted in a proliferation of care episodes which were of low value to the consumer, and often represented a financial burden. Some further stated that as well as a heightened burden on general practice, they had perceived a degree of deskilling among GPs due to the high proportion of time dedicated to completing tasks that could be undertaken by another professional and prevented them from working to their full scope.
- **Restrictions on the ability to work collaboratively** – barriers to individual practitioners' ability to work to scope of practice were seen as having the cumulative effect of reinforcing professional siloes. Professional culture issues, such as lack of interprofessional understanding and trust, combined with issues in the authorising environment were described as having this combined effect. This, in turn, prevented multidisciplinary care teams from working together in a streamlined way.

5.2 Legislation and regulation

5.2.1 Stakeholder views about the policy problem

Stakeholders were asked to respond to the following policy problem, and potential enablers to address this problem.

Legislation and regulation are key policy levers for scope of practice. Inconsistent regulatory approaches across health professions, named professions in legislation and regulation, and lengthy and inconsistent endorsement processes are all known barriers to health professionals working to full scope.

Potential enablers include:

1. Harmonising Drugs and Poisons legislation
2. Introducing risk-based & activity based regulatory processes
3. Streamlining endorsement processes
4. Reviewing authorising environments in self-regulated professions and the unregulated workforce

There was significant consensus that the above high-level policy solutions are well aligned to addressing known policy problems. Legislation and regulation were broadly discussed as a core element of the authorising environment for health professionals' ability to work to full scope of practice, alongside funding (see *5.5 Funding policy*). Stakeholders consistently described the rigidity of the legislative and regulatory environment, its lack of responsiveness to new models of care and evidence, and inconsistencies in legislation and regulation as the key barriers to their ability to work to full scope of practice.

Overly restrictive or specific legislation which limited scope of practice to particular professions, settings, employers, or named medicines (in the case of prescribing or dispensing) were viewed as a key area for change. Participants were also broadly in favour of moves to streamline the regulatory environment, such as reducing or consolidating reporting requirements across different programs. In nearly all cases, streamlining regulation was preferred to efforts to increase regulation – numerous professions warned against increasing regulatory scrutiny beyond what they saw as the already high level under Ahpra.

Legislative and regulatory barriers were described as having widespread impacts: restricting workforce mobility, creating complexity and confusion about what health professionals were authorised to do, and reducing the ability to work in multidisciplinary care teams. Ultimately, they were described as leading to reduced consumer access particularly in rural and remote areas with less choice of health professionals available.

Overall, participants further spoke in favour of more responsive approaches to legislative and regulatory reform. They explored opportunities to embed more continuous improvement, which was seen as better 'future proofing' the system and enabling innovative best practice internationally and within state and territory jurisdictions to filter into practice.

5.2.2 Level of support and consensus for potential policy enablers

5.2.2.1 Harmonising Drugs and Poisons legislation

This was the most strongly supported solution and generally viewed as the highest priority. Widespread frustration was voiced about the current inconsistency in Drugs and Poisons legislation across states and territories, and the impact this has on health professionals' ability to work across jurisdictions and settings. The example was frequently raised that pharmacists may be authorised to prescribe and dispense a different range of medicines across different States and Territories, and many representatives of the midwifery profession criticised restrictive formularies which limit endorsed midwife prescribing. Participants shared personal experiences where differences between States and Territories in authorities to prescribe, dispense or administer medicines served as a significant barrier, particularly in cross-border communities, and locums or other health professionals seeking to work on a mobile basis. Furthermore, it was observed that health professionals are increasingly providing their services remotely across different State and Territory jurisdictions using telehealth (for example, psychologists), raising questions about which legislation applies.

However, there were differences in opinion about how harmonisation should be implemented. Some stakeholders raised concerns that harmonisation would result in gravitating to the lowest common denominator, which would further limit scope, and multiple stakeholders expressed concern that harmonisation could prevent trialling of innovative practice within a particular state or territory. Others raised examples of good practice in State legislation which they believed should be expanded more broadly (for example, the Victorian legislation which enables the Secretary to enact policy without requiring approval through Parliament) or conversely, practice they believed to be prohibitive to full scope of practice, such as restrictive rules on nurse practitioner prescribing. A further good practice example raised across numerous jurisdictions was the CARPA Standard Treatment Manual for remote and rural practice (Northern Territory), which contains clear guidance about when health professionals can administer medicines, versus when they should refer.

Medical stakeholders frequently discussed specific requests in relation to Drugs and Poisons legislation, including expansion of the authority to prescribe certain medicines (such as ADHD and acne medications currently limited to specialist prescribing), and facilitating GP dispensing.

Harmonising Drugs and Poisons legislation was overall seen as a highly impactful reform with potential to significantly improve health professionals' ability to work to their full scope, and to do so consistently across jurisdictions.

5.2.2.2 Introducing risk-based and activity-based regulatory processes

The current approach to regulation of primary health care, of using named professions to regulate who is authorised to undertake a given activity, was widely described as arbitrarily preventing health professionals who were trained and competent to perform an activity from doing so in practice. Community paramedics were frequently raised as an example of a

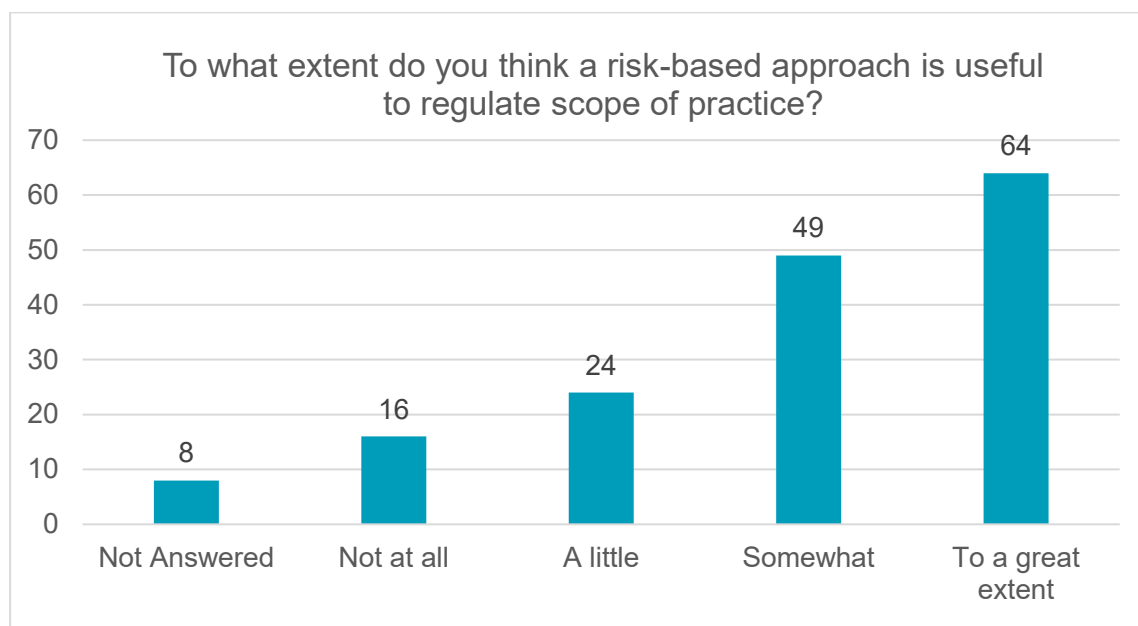
highly trained profession with variable authorisations across States and Territories; for example, a participant working in a Northern Territory service which had trialed a Remote Area Paramedic model expressed a fear that legislative or regulatory barriers would ‘clamp down’ and prevent them from practicing to the desired scope. Moreover, there was broad consensus that the barriers presented by named professions in legislation were such that the benefits of other policy solutions (particularly harmonisation) may go unrealised unless there was a corresponding shift towards risk-based regulatory processes.

Responses to risk-based and activity-based regulatory processes differed along professional lines and between stakeholders from different Modified Monash Model (MMM) areas. The strongest support for this policy solution came from non-medical professionals, who described potential benefits in terms of removing arbitrary restrictions along health professional or health setting-based lines. There was particularly strong support from participants working in regional and remote areas, who saw potential benefits for consumer access. While numerous rural GPs expressed active support on this basis, other medical professionals associated this policy proposal with potential risks to consumer safety. However, in rural and remote regions there was a consensus of a more balanced view of risk, in light of the present risk of lack of access to services. As summarised by a Remote Area Nurse respondent to the online survey:

A risk-based approach works well in a remote health service because it would remove the constant balance of the preservation of life verses deregistration. It is not always possible to contact a doctor in remote localities because of telecommunication limitations, this means that most days I dread emergency calls wondering if I might end up before AHPRA for attempting a lifesaving procedure that would be accepted practice in another part of Australia. Remote Area Nursing is not a recognised specialisation, so my profession is often grouped into the same scope as that of a hospital-based nurse and it is to the detriment of my patients. [Response 48]

Online survey respondents were asked about the extent to which they thought a risk-based approach was useful to regulate scope of practice. The most common response was ‘to a great extent’ (40% of responses), with the majority (70%) of responses agreeing a risk-based approach would be useful ‘somewhat’ or ‘to a great extent’.

Figure 1: Responses to Citizen Space survey question about risk-based approaches (n=161)



Many of those who responded in this way emphasised in open responses the international evidence for these models, the need for nationally agreed definitions of risk developed through engagement with peak bodies, and the need for the approach to be incorporated into education and training to ensure consistency. Some observed that self-assessment of risk is already common practice, particularly in professions such as midwifery, and that this risk threshold is influenced by the setting and MMM area in which the health practitioner is practicing.

Those who responded 'a little' or 'not at all' frequently highlighted the benefits of protected titles in ensuring a level of competency and patient safety, and concern that risk-based regulation could transfer authorisation to health professionals they perceived as less qualified. In addition, many expressed a view that role overlap, complexity and confusion would result from this policy change, potentially driving health professionals to work unsafely beyond their skill set and negatively impacting multidisciplinary teamwork. The risk of reductionism (i.e. clinical practice being reduced to a list of competencies, as discussed further in *5.4 Education and training*) was also raised, and some respondents reiterated the need for a team-based approach to accompany individual competency frameworks. One survey response by an allied health self-regulatory body noted that safeguards would be needed about allied health professionals working beyond their competencies, due to the lack of protected titles for professions outside of NRAS.

The solution was furthermore viewed as a critical pathway for 'future-proofing' legislation and regulation for future changes in the primary health care system. The common Australian practice of specifying professions, settings, medicines, etc in legislation and regulation was contrasted against other jurisdictions which introduce more flexibility by enabling future changes to scope of practice without needing to reform legislation. Representatives of the optometry profession raised this example particularly around prescribing of oral medicines, which is not authorised in Australia despite being required in certain clinical circumstances, and in relation to the inflexibility of the named medicines approach when new medicines come on the market:

“In optometry our barrier is based on a list of drugs we can prescribe. Every time a new drug comes on the market, we have to go through a loop. We have been trying for 10 years to be authorised to prescribe oral medicines which limit our scope of practice.” [Melbourne consultation]

Introducing risk-based and activity-based regulatory processes was overall seen as having the potential to significantly impact health professionals’ ability to work to their full scope, albeit with some potential risks which would require careful consideration in how this solution were to be implemented.

5.2.2.3 Reviewing authorising environments in self-regulated professions and the unregulated workforce

While there was broad consensus that there was a need to address challenges in this area, there was no clear consensus around how to implement change to authorising environments. It should be noted that many participants expressed concern about the conflation of self-regulated and unregulated workforces implied by this policy solution, and there was general consensus that different solutions would apply to self-regulated professions’ and unregulated workforces’ scope of practice.

Potential unintended consequences of perceived overregulation were also raised. Participants in the Northern Territory expressed a direct warning about increased regulation as a solution, and provided clear examples where they had observed reduced ability of Aboriginal and Torres Strait Islander Health Practitioners to work to their previous scope, and a decrease in the size of this workforce after it was brought under NRAS.

Related to the issue of named professions, the exclusionary impact of legislation and regulation which refers in shorthand to the Health Practitioner Regulation National Law (hereafter ‘the National Law’) or to ‘health practitioners’, was frequently described as a significant issue. The effect of doing so (i.e. remaining silent on non-NRAS professions and/or non-practitioners) had a demonstrable effect in restricting the scope of practice of non-NRAS regulated professions, particularly self-regulated professions. Representatives of these professions discussed how this, combined with interprofessional cultural issues, served to devalue their profession and competency. Participants from self-regulated professions described how they were not only constrained in their individual scope of practice, but could be constrained from working in multidisciplinary care teams.

Numerous participants requested formal recognition of the National Alliance of Self Regulating Health Professions (NASRHP) as the authoritative body overseeing self-regulating health professions, mirroring recognition of NRAS, however this view was not unanimous. It was also observed that care would need to be taken in implementing risk-based regulation, such that it did not unintentionally exclude self-regulated professions.

In relation to unregulated workforces, participants observed a potential risk of workers working beyond their scope of practice due to a lack of understanding of appropriate scope. For instance, participants shared personal observations of personal care workers administering medicines which were beyond their authorised scope of practice. This concern was voiced particularly in light of inconsistencies in assessment of risk between different professions.

In particular, although some participants voiced explicit support for adding more professions to NRAS, this was a point of contention for many others. Some participants from self-regulated professions argued that their professional practice carries a level of risk similar to that of NRAS-regulated professions, and should therefore be subject to further regulation under NRAS. Meanwhile, arguments against additional regulation of self-regulated professions included the perception of an already adequate level of regulation, given that self-regulation typically mirrors the regulatory approach under the National Scheme. It was regularly suggested that one way to improve authorising environments for self-regulated professions would be to address the shorthand or proxy citation of the National Law in legislation and regulation concerning scope of practice, however it was broadly acknowledged this change would not resolve all issues in the authorising environment.

Many expressed views that unregulated workforces including assistants and technicians were a key resource and opportunity to provide more efficient care and relieve other health professionals, allowing them to work at full scope, particularly in under-resourced areas and regional Australia. However, numerous stakeholders were unhappy with the existing status quo of the regulation of these workforces, as they observed significant variability in competencies. This was posed as both a risk in terms of expanding unregulated workforces' scope of practice, and an opportunity to increase regulation to enhance consistency, quality and safety. Some participants warned not to increase regulation of unregulated workforces 'too early' where efforts to standardise competency or scope were already underway.

There was broad agreement that authorising environments in self-regulating professions were preventing full scope of practice, particularly embedded in legislation that referred in shorthand to the National Law. Consensus was not reached on whether bringing additional professions under NRAS would positively or negatively impact self-regulated professions.

5.2.2.4 Streamlining endorsement processes

Some support for reducing endorsement requirements was expressed by particular professions, such as psychologists and midwives, who critiqued the two-tier system of endorsement and the substantial practice hours requirement for their respective professions. However, streamlining endorsement processes was seen as less impactful for most other professions, for whom endorsement was more likely to be discussed in terms of endorsements going unrecognised (see 5.3 Employer practices and settings) or meeting other legislative barriers. Streamlining in terms of harmonisation of what activities health professionals were authorised to perform, per above solutions, was broadly viewed as a more impactful priority solution. Moreover, stakeholders voiced broader views about increasing flexibility and access to post-professional entry learning (see 5.4 Education and training).

Streamlining endorsement processes was mainly a priority for those professions directly affected by rules perceived as arbitrary or inconsistent, and could have the potential to significantly impact these professionals' ability to work to their full scope of practice.

5.2.3 Additional perspectives

Other policy solutions outside of those provided in survey and consultation questions were around **medical indemnity insurance**. There was significant discussion on the environment of risk around working to full scope of practice, with many (particularly from medical professionals) raising a potential risk that indemnity providers could interpret any changes to scope of practice as attracting a higher level of risk, and refuse coverage on this basis. The participants who held this view emphasised that decisions made by indemnity insurance providers to cover (or not cover) particular activities for particular professions could serve to restrict scope of practice, even in the presence of other legislative and regulatory enablers. An in-practice example was raised across multiple jurisdictions, that nurses are prevented from performing skin checks due to lack of indemnity coverage, effectively restricting access to skin checks in regional and remote communities where only nurses are available to provide this service. Some participants expressed doubts that indemnity cover could be obtained at all for certain 'top of scope' activities if scope were to be expanded.

Particular concern was expressed by medical professionals that it would be inappropriate for their own indemnity to cover activities by non-medical providers falling under their supervision, e.g. general practices which employed non-medical professionals. However, many non-medical professionals countered with the fact that they hold their own health professional indemnity insurance which could be expected to cover their full scope of practice. These issues highlight the importance of working with indemnity insurance providers to progress reform in this space, aligning with other policy reforms. The New Zealand model of medical indemnity was raised as a good practice example, as limited liability is extended via a system of pooled funding.

Participants further raised potential **reform to regulation restricting practice of certain groups**, such as overseas trained health professionals and people returning to work after a career break. The latter group, which was observed to include many mothers returning to work after starting a family, were described as disadvantaged by 'recency of practice' requirements. Meanwhile, overseas trained practitioners were described as both experiencing significant and arduous processes to re-qualify against Australian regulatory standards and, once practicing, being unable to perform certain services they had done in the country where they were trained (one example given was of a UK-practicing GP who was no longer able to perform minor surgeries after beginning to practice in Australia).

5.2.4 Key areas of crossover with other themes

Funding policy: The fundamental importance of having funding follow the legislation and regulation was emphasised across all consultations, and funding policy was seen as such a core element of the authorising environment that it often had a 'quasi-legal' effect as a lever to scope of practice. Participants expressed that enabling particular activities via changes to legislation or regulation would effectively be meaningless without funding mechanisms that support all relevant health professionals to perform that activity. A significant proportion of survey responses to questions about legislation and regulation discussed funding policy in some depth, highlighting the strength of the relationship between the two aspects of the authorising environment.

Employer practices and settings: The lens of leadership and culture was described at the critical pathway for how legislation and regulation filter into practice at the employer level. Although legislation was acknowledged as impacting culture across the system, service-level culture, leadership and governance play a critical role in enabling (or restricting) legislative change to impact scope of practice on the ground.

5.3 Employer practices and settings

5.3.1 Stakeholder views about the policy problem

Stakeholders were asked to respond to the following policy problem, and potential enablers to address this problem.

Enabling and authorising environments, at the service-level and across multi-service care teams, are critical for health professionals to work to full scope of practice. Key barriers include inconsistent authorisation to perform particular activities across settings, gaps in employer recognition of endorsements and skills, and insufficient employer support for multidisciplinary care teams. These barriers interact with other system-wide barriers and enablers.

Potential enablers include:

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

5.3.2 Impact of the problem

Stakeholders identified significant barriers at the employer level that impact health professional scope of practice. Barriers to working across different health settings, and for different employers were well described, and identified as restricting individuals and teams from working to their full scope of practice. There was broad agreement for improving consumer-centred care by applying a needs-based lens to primary care. Stakeholders also agreed that inconsistent recognition of health professional capabilities and qualifications acted as a barrier to full scope of practice. Discussion of this theme interfaced to a significant extent with other themes. Stakeholders highlighted funding policy, legislative and regulatory, education and training and technology-related factors that impact employer-level practices. There was significant discussion focused on the professional culture and leadership practices which underpinned employer practices, making this a key consideration in how to address the above policy problems.

5.3.3 Level of support and consensus for potential policy enablers

5.3.3.1 Establishing models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers

Multidisciplinary care teams were viewed as contributing to the delivery of needs-based care, without which health professionals would continue to operate largely in siloes. Stakeholders held varying perspectives on the practical and operational characteristics of multidisciplinary care teams. However, a risk was expressed that overly disease-focused care teams, while useful for some consumers with a specific condition, may be inflexible in meeting the needs of people with multiple comorbidities. Stakeholders from regional and remote areas indicated greater acceptance and 'less anxiety' about working in teams comprised of multiple health professionals. This group also highlighted the importance of teams delivering care close to the patient rather than requiring patients to travel to access care.

Stakeholders described care teams which varied in their interprofessional connectedness. Comments highlighted differences between multidisciplinary care (in which care is provided by a range of health professions that work largely independently) and interprofessional or collaborative care (in which multiple health professions work together to discuss, determine and provide the most appropriate care for the patient). Stakeholders indicated a desire for teams to exist across both health settings and employers in order to effectively meet the needs of the community.

A commonly expressed view was that the multiprofessional team should respond to patient need using the most appropriate team member/s to meet that need rather than specified professions. There are multiple barriers to achieving this, particularly the use of protected titles and named professions in legislation and regulation (see 5.2 *Legislation and Regulation*), and funding policy which is highly specific about who is funded to deliver services (see 5.3 *Employer practices and settings*). Stakeholders highlighted the trust that consumers place in the team and the lack of concern most have for who (i.e. which profession) is providing the care, provided it is of appropriate quality. Further, many respondents indicated that leadership within the team should fall to the most relevant health professional, rather than deferring to a specific profession.

“Priority must be given to the most accessible and safest outcome for patients; not professional competition or monopoly by one health provider over another to perform activities that can be safely performed by either practitioner as it falls within their scope of practice.” [Email submission 22]

Trust was frequently identified as an important foundation for primary care teams. Stakeholders suggested that trust is developed through communication, shared experiences, a clear understanding of capabilities, roles and responsibilities and defined and recognised team-based practice expectations. Participants universally agreed that trust is foundational to effective team-based, person-centred care.

Co-location of care teams, such as those established in general practice, was identified as advantageous in facilitating interprofessional collaboration and in simplifying consumer access and governance structures. However, stakeholders also described benefits of multi-employer care teams which afford greater flexibility to meet consumer need.

Stakeholders varied in their view of the role of the general practitioner (GP) in care teams. Many GPs described multidisciplinary care teams in the context of the current system in which medical professionals (especially GPs) play a central/leading role and view their profession as the most (if not only) appropriate choice to lead and coordinate care across the team. This was linked by some to a perception that medical indemnity may require the GP to assume overall accountability for the multidisciplinary care team. However, most non-medical professionals described care teams which were constructed around the needs of the consumer and led by the most appropriate health professional according to consumer need and preference. A smaller number of GPs (particularly in regional and remote areas, operating from circumstances of scarcity) agreed that there were opportunities for other non-medical professionals to lead care teams, depending on local community needs. This discourse was also reflected in discussions about (and has implications for) education and training, funding and technology.

Participants were highly supportive of multidisciplinary care models. Improvements in interprofessional trust, understanding and respect, alongside improved consumer experiences of care and health outcomes, were commonly viewed as key potential impacts of models of multidisciplinary care for target patient cohorts and strengthening support for health professionals to work together across employers.

5.3.3.2 Establishing more consistent approaches to recognition of qualifications and competencies across settings

Stakeholders agreed that inconsistent recognition of health professionals' competencies and qualifications acted as a barrier to full scope of practice and contributed to significant practitioner frustration. The resultant impact on interprofessional understanding and respect, and by extension professional satisfaction and retention, were also broadly discussed as a source of frustration. This sentiment was also highlighted when participants discussed education and training (refer *Section 5.4.2 Education and Training* for further commentary).

A national regulatory approach to the definition of scope for individual professions, linked to education and training, was consistently raised as an important contributor to recognising the contribution of health professionals within the primary care team. Established pathways for advancing practice was also highlighted as important to ensure teams recognise individual skills that inform clear and appropriate practice expectations.

Establishing more consistent approaches to recognition of qualifications and competencies across settings was viewed as supporting clarity regarding the potential contribution of individual professions to the primary care team and to an improved overall functioning of the team.

5.3.3.3 Reviewing clinical governance mechanisms in primary health care settings

Stakeholders acknowledged the existence of national quality and safety standards applicable to primary care. While a small number voiced support for a national mandated approach to the implementation of these standards, the difficulty of doing so across the vastly dispersed

primary care system was raised by many others as a significant challenge to achieving this outcome.

The use of existing resources to provide governance mechanisms specific to primary care was raised. Primary healthcare networks (PHN) were identified as potentially contributing structured support for smaller, disparate teams, including those that operate virtually. It was highlighted that PHNs operate differently across the country which may impact the ability for this resource to provide consistent governance.

The importance of utilising governance mechanisms to ensure patient safety was highlighted. Incorporating risk identification and mitigation strategies was viewed as a primary concern, particularly where professional roles and scopes are modified. The importance of a reflective approach to practice, combined with effective quality assurance and improvement processes was identified and noted to already exist in many areas. The unique nature of primary care, compared to secondary or tertiary care, and the need to employ systems that support outcome review and practice improvement within this context were highlighted in stakeholder views and identified as particularly relevant to sole practitioners.

Implementation of mechanisms to review performance, including peer review, and quality assurance processes to ensure patient safety, were also supported as quality assurance mechanisms.

Stakeholders suggested that innovation in operational structures, such as reporting lines, may be useful in practice to support the multiprofessional primary care team. For example, nurse practitioners will commonly report to a nurse manager. However, given the nurse practitioner's advanced skills, it may be more appropriate to report to a medical colleague, particularly where the nurse practitioner requires mentorship.

Supporting primary care providers through clear governance mechanisms was viewed as providing structural strength for the primary health care team and significant patient safety assurances.

5.3.3.4 Tasks requiring employer support

Participants who contributed to the online Citizen Space survey were asked to respond to the following question: *Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?*

In response, participants described a range of activities. Some suggested activities would require specific legislative amendments (e.g., prescribing medicines), others regulatory and/or funding adjustments (e.g., altered referral mechanisms, provision of telehealth services).

Other responses included: vaccination, transdisciplinary assessments, provision of specific education (childbirth, early parenting, sexual health and reproduction), preventative health interventions, admitting privileges, research and support to practise collaboratively.

5.3.4 Additional perspectives

Employer contribution to optimal team-based care. Stakeholders described a range of activities considered important for employers to undertake to support the primary care team to achieve optimal function. These include:

- **Remuneration** – provision of remuneration commensurate with recognised training and skill.
- **Skill recognition** – establishment of a process for recognising professional experience and non-formal education in addition to formal qualifications.
- **Clear practice standards** – provision of clearly defined expected standards for practice that support collaborative care, including describing roles and responsibilities for team members.
- **Cultural influence** – facilitation and expectation of collaboration between team members, including fostering openness and accountability between members of the team.

It was also noted that in many cases, health professionals are self-employed and as such employer contributions are unavailable.

Equity. Stakeholders identified inequality in several areas. Differences were highlighted between professions in their access to funding and leave to complete education and training, access to visiting and admitting rights and in the remuneration to complete specified tasks (e.g., hand therapy). Self-regulated professions were noted to receive remuneration inconsistent with regulated professions. Opportunities to occupy leadership roles were also noted to be inconsistent between professions. Health professionals may also receive inconsistent remuneration for completing the same duties in secondary care compared to primary care.

Culture. Employers were identified as important contributors to an improved culture of collaboration and trust between professions (including regulated and self-regulated) and a patient-focused approach to care. It was noted that this collaborative approach should be expected and rewarded. Stakeholders also viewed the employer as playing a vital role in ensuring staff feel supported and their skills appreciated.

Industrial considerations. Stakeholders highlighted the need for a range of provisions to be included in industrial agreements. These include fair remuneration, consistent with qualifications and experience, fair workload expectations and access to required digital technology (including patient specific information) to support team-based practice and patient safety. These issues were identified as particularly important where roles and services are modified and/or expanded. The need to harmonise enterprise agreements was raised as a contributor to health professional career paths and to support professional mobility.

Policies and procedures. Stakeholders appreciated the need for employers to clearly define and reinforce their expectations of practice, including role descriptions. Policy areas that were identified as important in this context included: communication between professionals, conflict resolution mechanisms, expectations for respect, feedback processes and quality assurance mechanisms that support patient safety. The importance of maintaining policies and procedures that accurately reflect contemporary practice was identified as a contributor to optimal team function.

Broad view of the health workforce. Stakeholders indicated that a long-term, holistic view of the health workforce is required. Suggested inclusions in this approach were:

- **Defining and promoting the scope of practice for all professions.** This was viewed as contributing to interprofessional trust and cohesion as well as a broad view of the profession/s most suited to address specific community need.
- **Identifying emerging roles and developing education and training programs** to prepare the workforce in advance.
- **Establishing employment opportunities** to contribute certainty for existing and prospective health professionals.
- **Responding to health needs** (either local or national) with flexibility and innovation.
- **Recognising, planning for and addressing the needs of specific communities** including those in rural and remote areas and First Nations peoples.

5.3.5 Key areas of crossover with other themes

Legislation and regulation: Employer practices are influenced by both legislation and regulation. Regulatory mechanisms that support patient safety remain a significant consideration in all policy initiatives.

Funding policy: The role funding played in incentivising and disincentivising employer behaviours was described as paramount, making this a significant policy lever for influencing employers to enable their employees to work to full scope of practice.

Technology: Access to digital platforms that facilitated multidisciplinary care teams and other employer-level practices was important. It was raised that while employers held some level of influence over technology systems, some lay outside their area of influence.

Leadership and culture: Establishing a culture of cohesiveness is paramount to team-based care and the achievement of optimal patient outcomes.

5.4 Education and training

5.4.1 Stakeholder views about the policy problem

Stakeholders were asked to respond to the following policy problem, and potential enablers to address this problem.

The Australian primary health care system features a proliferation of education and training requirements across health professions, which differ depending on how a health profession is regulated. Consultation findings indicate access to continuing professional development is not consistently supported in practice, and training requirements for similar/common competencies apply inconsistently across professions in some cases.

Potential enablers include:

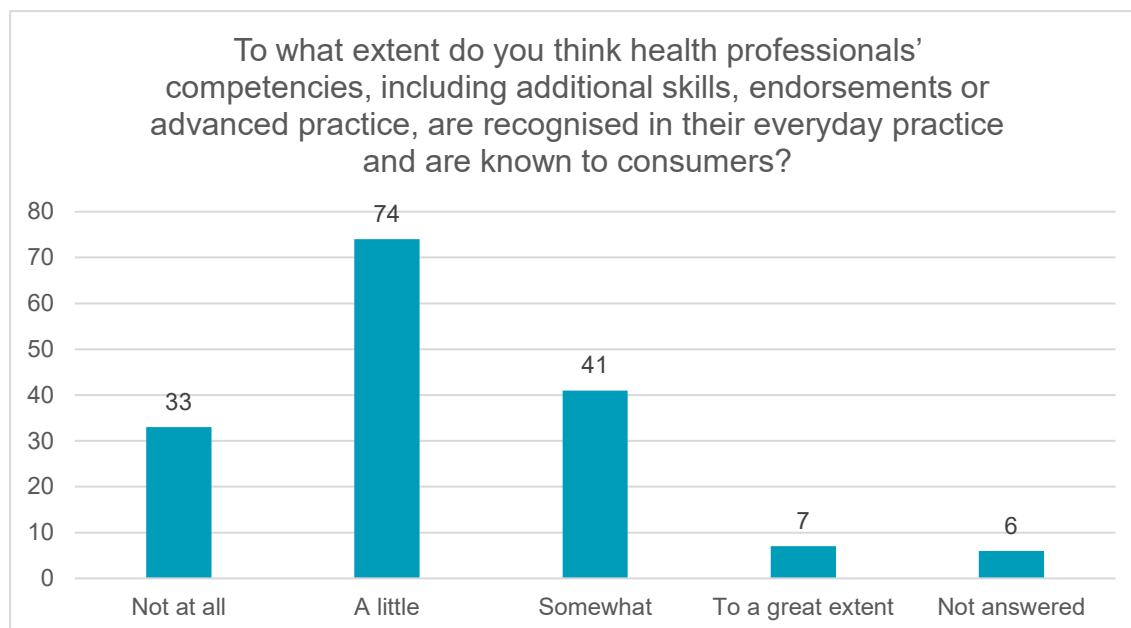
1. Establishing greater system-wide clarity about requirements of profession entry learning.
2. Establishing a nationally consistent approach in promoting and implementing common interprofessional competencies.
3. Promoting multiprofessional learning.
4. Ensuring ongoing education and training are accessible.

5.4.1.1 Impact of the problem

Stakeholders expressed concern that many health professionals are unable to fully contribute their skills to the primary care team due to a poor understanding of the role of individual professions and/or a failure to fully recognise the specific skills an individual has acquired through education, training and experience. Additional factors identified as impeding optimal skill utilisation include funding arrangements and legislative / regulatory barriers. Under-utilisation of professional skill was described as demotivating and negatively impacting workforce retention.

Stakeholders who responded to the online Citizen Space survey were asked to indicate the extent to which they thought health professionals' competencies are recognised in their everyday practice and are known to consumers. The majority (71%) answered either 'a little' (46%) or 'somewhat' (25%) while over one-fifth believed health professionals' competencies were 'not at all' recognised in everyday practice.

Figure 2: Responses to Citizen Space survey question about recognition of health professionals' competencies in practice (n=161)



Stakeholders identified that primary care professionals face significant challenges in completing required and/or desired education and training. Poor access to education and training post-entry qualification was viewed as impacting the ability to meet mandatory continuing education requirements, and identified as preventing the acquisition of skills and knowledge to support or enhance practice scope.

A commonly expressed concern was that for some professions, students face significant challenges in completing required practical training as part of the pre-entry curriculum. Challenges described include inadequate placement opportunities or the need to travel, at own expense, to complete training. The impact of these challenges includes unsuccessful completion of the program or a significant financial and personal burden to do so. Stakeholders also identified markedly fewer opportunities for students to complete practical training in primary care, resulting in fewer than required graduates who are equipped to begin work in this setting.

5.4.2 Level of support and consensus for potential policy enablers

Participants were supportive of all proposed policy options.

5.4.2.1 Establishing greater system-wide clarity about requirements of post-entry learning

Stakeholders indicated strong and almost unanimous support for national consistency in the provision of post-entry education and training. Stakeholders identified a need for education and training to be developed according to consistent national standards and for a common language to describe post-entry qualifications. These factors were viewed as contributing to a shared understanding of the contribution of post-entry qualifications to practice scope and recognition of professional skill.

National credentialing was supported by the majority of stakeholders as a mechanism to contribute to national consistency in education and training. Local credentialing was viewed as important to dovetail with national processes, to ensure training relevant to the community context. Stakeholders warned against the use of credentialing as a 'tick box' exercise, noting that excessive credentialing requirements are inefficient and burdensome for health professionals. Contributors from the midwifery profession highlighted the challenging and sometimes frustrating process that necessitates them to undertake frequent re-credentialing when employed across multiple sites.

While national credentialing was generally supported, the importance of recognising the generalist nature of primary care was highlighted by many participants and the relevance of deconstructing the generalist skillset to a credential (or series of credentials) questioned. An alternate view held that team-based care should be characterised by regular feedback between team members to support professional development and highlight areas for improvement. It was also felt that there are aspects of primary care for which the best preparation is supervised experience rather than a specific credential.

National recognition of health professional skill was viewed as providing an improved understanding of the potential contribution of each profession to the primary care team. At a national level, identifying and promoting the entry-level skills of each health profession, consistent with education and training programs, was viewed as important to optimise skill utility in primary care. Stakeholders described experiences where professionals have become deskilled due to the inability to practise to their full scope, resulting from poor recognition of professional skills.

Where health professionals have completed additional post-entry qualifications, it was considered important to acknowledge, value and utilise the additional qualification in the provision of patient care. As outlined above, national consistency in post-entry education was viewed as contributing to greater skill recognition. The use of a digital skills passport was commonly highlighted as useful in this context.

Stakeholders recognised the importance of facilitating consumer understanding of health professional skill, including where additional skills have been acquired through post-entry education and training. A range of methods were proposed to support consumer understanding and to contribute to an informed choice of health professional, including education campaigns that describe health professional roles.

In addition to promoting a greater appreciation of health professional skill, establishing greater system-wide clarity about requirements of post-entry learning was linked to workforce mobility, flexibility and responsiveness, noting that employment opportunities across jurisdictions may be more attractive where qualifications are readily recognised.

5.4.2.2 Establishing a nationally consistent approach in promoting and implementing common interprofessional competencies

Education and training delivered in the pre-entry period was acknowledged as providing both profession-specific knowledge and skills and interprofessional skills. Stakeholders acknowledged that health professions regulated under NRAS are required to provide

interprofessional learning as a component of entry-level programs. The importance of interprofessional skills as a contributor to collaboration in the primary care team was acknowledged, however, stakeholders felt that greater emphasis could be placed on the development of these important skills, including the assessment of student abilities in this context. Stakeholders also identified a need for a common language in the context of interprofessional education and for the expected competencies of the graduate to align between professions. There was clear support for the development of an Australian competency framework as a foundation for interprofessional education and training in the entry-level curriculum.

Stakeholders suggested that accreditation panels should comprise multiple professions and that consumers be engaged to contribute to the design, development and delivery of interprofessional content, where possible, to provide students a broad appreciation of the impact of patient-centred collaboration.

Where experiential learning is required as a component of pre-entry programs, flexible supervision options that include inter-professional supervision, where practical, was suggested as an important contributor to interprofessional learning and to address workforce shortages that may impede practical learning opportunities.

Stakeholders acknowledged the importance of a collaborative workplace culture in supporting interprofessional collaborative practice. Concerns were raised that despite completing interprofessional education during pre-entry programs, a poor workplace culture may prevent early career professionals from practising in a collaborative manner. Stakeholders suggested the importance of redefining workplace culture to support an inclusive attitude to all primary care professionals.

5.4.2.3 Promoting multi-professional learning

The importance of multi-professional learning as a contributor to strong collaboration in primary care was acknowledged by majority of participants. Stakeholders recognised that post-entry education and training is commonly, although not exclusively, provided in a profession-specific manner which fails to contribute to a team approach to care. While examples of multiprofessional learning were identified, a commonly held view that this could be enhanced was apparent. Where qualified health professionals are enabled to learn together, benefits were viewed as directly contributing to enhanced care. Regional and remote health settings were identified as innovative in their provision of multi-professional learning opportunities.

5.4.2.4 Examples of multiprofessional learning that contribute to optimised primary care teamwork

A range of health professional groups were identified for which learning together to support working together appeared logical. Participants described the following examples:

- Pre- and ante-natal care provided by midwives, obstetricians, general practitioners, lactation consultants.
- Community-based care for musculoskeletal issues provided by physiotherapists, podiatrists, chiropractors, osteopaths, exercise physiologists.

- Mental health care provided by psychiatrists, psychologists, community mental health nurses, peer workers.

Stakeholders recognised a range of specific capabilities, or skillsets, that are common to multiple health professions e.g., basic life support, vaccination, management of acute mental health episodes, insertion of intravenous cannulas, catheter management. Stakeholders from regional and remote settings described a common and accepted workforce model characterised by multiple professions, particularly allied health, equipped with the skills to undertake common roles. In many cases, the driver for this skill sharing was identified as scarce health professional resources. Learning and practising essential context-relevant skills and tasks was highlighted as a valuable contributor to team cohesion and trust.

Work conducted more than a decade ago, and highlighted by consultation submissions, identified a range of activities undertaken by multiple allied health professions.^{1 2}

Stakeholders suggested the need for appropriate training and governance structures to support this type of skill sharing. Support was expressed by the majority, but not all, stakeholders for improved consistency in the education and training provided to prepare professionals to contribute to the primary care team by undertaking common tasks.

Establishing a nationally consistent approach in promoting and implementing common interprofessional competencies was widely supported as contributing to a strong primary care team that understands and respects the contribution of each profession and has the skills to work cohesively to meet consumer and community need.

5.4.2.5 Ensuring ongoing education and training are accessible

Stakeholders consistently identified the unique challenges faced by primary care professionals in accessing and completing post-entry education and training. Many of these challenges were viewed as particularly significant for those working in regional and remote areas. For example:

- **Financial impact** – described as the cost to access education and training (including HECS/HELP fees for formal programs and/or registration fees for continuing education sessions or discrete training modules) and, where not available online, travel costs to participate in person. Where formal post-entry level education and training programs are completed, remuneration commensurate with the additional qualification was viewed as imperative, yet infrequently provided.
- **Time impact** – identified as the disruption of work/life balance associated with completing education and training outside of work hours.
- Some participants identified an **inability to access quality training** programs and/or learning institutions.
- **Inflexibility in required education and training** – highlighted as demotivating and potentially impacting staff retention. While the need to ensure professionals are safe to

¹ Greater Northern Australia Regional Training Network. Project Report: Rural and Remote Generalist - Allied Health Project: Report Attachments 2013

² Greater Northern Australia Regional Training Network. Project Report: Rural and Remote Generalist - Allied Health Project. 2013.

practise was universally acknowledged, stakeholders indicated the need for innovative and flexible methods to achieve this. Examples provided describe the inability to reasonably modify mandatory requirements consistent with individual circumstance e.g., whether working full or part time, the requirements are equivalent. In addition, stakeholders indicated that experienced professionals are transitioning to retirement due to the burden of meeting mandatory training expectations. In regional and remote areas, this loss of experienced professionals further impacts an already under-resourced workforce. Suggested alternate methods to ensure safe practice included in situ peer review conducted according to nationally agreed standards.

Consistent with these views, a range of potential solutions were suggested, including:

- **Financial support** to access and undertake education and training to contribute to maintaining and/or enhancing practice scope. For primary care professionals who are self-employed, the importance of access to quality locum support was highlighted to prevent lost income while completing education and training.
- **Employer support** to complete education and training, including permitted time and recognition of newly acquired skills.
- **Nationally accredited discrete education and training**, accessible to multiple professions, that can be undertaken alone or in combination to support achievement of a higher qualification (e.g., a certificate).
- **Mentorship** to support ongoing professional development.

Ensuring access to continued education opportunities was viewed as an important mechanism to support the individual to maintain and advance their skills and the primary care team to achieve its optimal capacity.

5.4.3 Additional perspectives

Many stakeholders highlighted the significant role of supervised practical training (e.g., periods of practical placement, internships) in the development of health professional skills and knowledge. There was a clear view that learning undertaken in the practice setting provides a context-rich experience for the learner and should be encouraged in educational programs. The significant contribution of learning experiences undertaken in rural and remote settings was highlighted. Stakeholders described the importance to community of developing and maintaining a stable health professional workforce and described examples of rural communities supporting student placement experiences to contribute to workforce stability.

However, the challenges of providing high quality practical training opportunities were widely acknowledged, including inadequate training positions, and the requirement to provide supervisors drawn from an under-resourced health workforce. These issues impact the student who may be required to travel, at own expense, to undertake required experiential learning, and the existing workforce which is required to maintain current service provision and provide student supervision and mentorship. As a consequence, early career professionals may be underprepared to complete their role. Consistent standards for supervision were highlighted as an important contributor to quality practical training.

Relatedly, stakeholders frequently expressed the need to recognise the full capabilities of the early career professional **and provide greater support** during the period of transition from student to professional. Supervision and/or mentorship were frequently highlighted as essential supports during this period. However, as described above, the existing workforce finds it challenging to offer focused support and frequently this support is provided without formal supervisory training and is commonly an unpaid role. This was noted to result in a reliance on education providers to produce 'work ready' graduates capable of contributing to care without support and/or a preference to employ professionals who have undertaken early career training in other sectors e.g., secondary care. However, it was suggested that cross-sector training may be inadequate to develop the capabilities required for effective primary care. Transition to practice programs were identified as an important method of supporting early career professionals, however, are not routinely available.

Post-entry training was identified as specifically relevant to those working in rural and remote areas. Stakeholders indicated that many entry-level programs provide knowledge and skills most relevant to practice in metropolitan areas. Consequently, there is a need for additional context-relevant training when professionals commence rural practice, placing a significant burden on an under-resourced workforce.

Stakeholders frequently urged greater **recognition and utilisation of the generalist practitioner**, acknowledging the important contribution health professionals equipped with a broad range of skills make to primary care, particularly in regional and remote communities. Support was expressed for the continued design and refinement of educational programs that develop generalist skills in all health professions. The importance of securing appropriate funding mechanisms for the generalist was also highlighted.

Concern was raised that **primary care is not** always evident (or not prioritised) **in pre-entry curricula**. Stakeholders viewed this as a considerable gap, highlighting that for many professions, placement and/or immediate post entry qualification experience is commonly gained in the acute care setting which, as indicated above, was viewed as less than optimal to prepare professionals for work in primary care.

Participants highlighted the importance of all health professionals **recognising their scope of practice** according to personal and professional competence. There was a call for this to be explicitly included in the pre-entry curricula for all health professionals, reinforced by experiential learning experiences and continued as an expectation of lifelong practice.

The importance of the para-professional workforce was repeatedly raised. Stakeholders indicated that national recognition for assistants in health, technicians, peer workers and carers (e.g., those working in aged care) and consistent education and training for these groups was important.

Similarly, the self-regulated workforce was identified as requiring specific and careful consideration in policy decisions.

Stakeholders indicated the importance of **acknowledging that each profession brings specific capabilities to the primary care team** and should be recognised for the unique lens with which they view the patient. In this regard, grouping professions together as 'allied health' or 'non-medical' tends to present the incorrect view that all group members have similar capabilities. Stakeholders also noted the complexity of the allied health workforce,

which comprises a significant proportion of the health workforce and includes regulated, self-regulated and unregulated professions.

5.4.4 Key areas of crossover with other themes

Employer practices. Effective education and training to support primary care requires adequate resources, including funding for both pre- and post-entry level programs. In addition, health professionals require support to undertake both required and practice-relevant additional education and training to support their practice scope and appropriate recognition, including remuneration, when qualifications are achieved.

Relevant employment prospects are required to encourage professionals to complete post-entry education and training.

Legislation and regulation. The inability to practice to full potential, commensurate with completed education and training, was commonly impacted by legislation and regulation.

Leadership and **culture** within the primary care team was viewed as essential to support and enhance optimal care. Stakeholders indicated the importance of being recognised for their skills and permitted to undertake the roles for which they are appropriately trained. Achievement of this requires leadership and a supportive workplace culture.

5.5 Funding policy

5.5.1 Stakeholder views about the policy problem

Stakeholders were asked to respond to the following policy problem, and potential enablers to address this problem.

Funding policy and payment models underpinning the primary health care system have wide-ranging impacts on the ability of health professionals to work to full scope of practice. There are concerns the existing fee-for-service funding mechanism is not flexible or broad enough to effectively support long-term care relationships, continuity of care or multidisciplinary care.

Potential enablers include:

1. Using block, bundled and blended funding to deliver care flexibly
2. Funding and payment types which incentivise working as multidisciplinary care teams
3. Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules

Funding episodes of care regardless of profession (i.e. a single MBS rate for a particular activity)

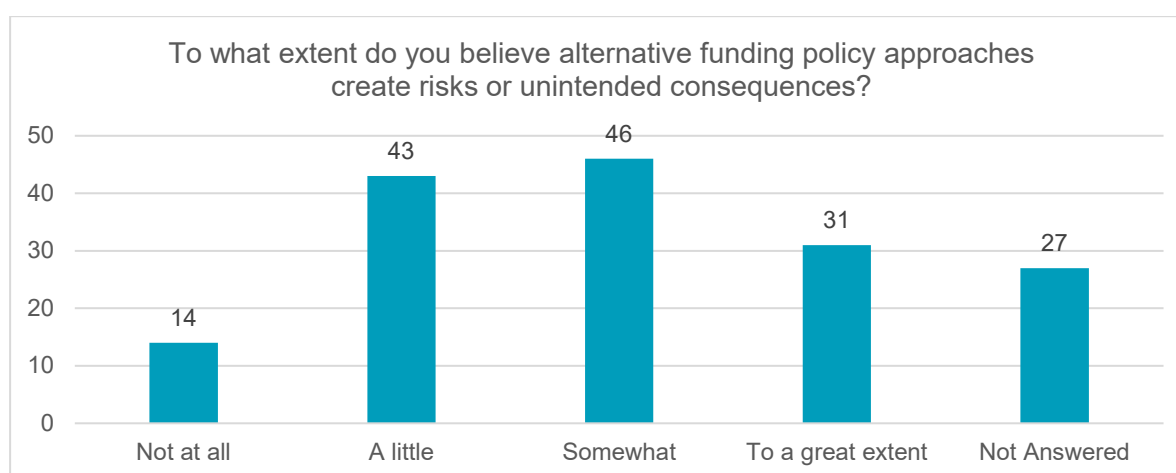
The majority of stakeholders felt strongly that funding policy reform was required in order to effect any change to health professionals' ability to work to full scope of practice. Funding policy was viewed as one of the core components of the authorising environment, alongside legislation and regulation, which was expected to have the greatest impact on scope of

practice. Some went as far as to posit that without funding policy changes, policy solutions in any other areas would not be borne out in practice, as working to full scope would continue to be financially disincentivised in many cases.

Accordingly, broad support was expressed throughout the consultations for all four proposed policy solutions, which were each seen as enabling different aspects of scope of practice. This was underpinned by overarching support for the multidisciplinary care team model, and support for greater flexibility via funding mechanisms to drive better utilisation of all members of the health care team.

However, the need to consider potential perverse incentives or unintended consequences was frequently expressed, and it was broadly acknowledged that any change to funding policy could carry the potential for unintended consequences. Participants who responded to the Citizen Space online survey were asked about the extent to which they believed alternative funding policy approaches would create risks or unintended consequences; the majority (55.3%) answered 'somewhat' or 'a little', and a further 19.3% believed alternative funding policy would 'to a great extent' pose risks or unintended consequences.

Figure 3: Responses to Citizen Space survey question about risks or unintended consequences of alternative funding policy



However, a subset of participants argued strongly that the potential presence of 'bad actors' should not constitute a barrier to implementing funding policy which potentially stood to benefit the majority of health professionals (and consumers) from a scope of practice perspective. Moreover, the majority of responses to a follow-up survey question 'How do the risks of alternative funding policy approaches compared to the risks of remaining at status quo?' expressed the opinion that the risk of remaining at status quo is greater than risks posed by policy change. The status quo funding model was widely described as unsustainable and even 'catastrophic' if it were to continue. Evidence-based co-design and consultative approaches, and independent evaluation were raised as ways of mitigating risk.

5.5.2 Level of support and consensus for potential policy enablers

Participants were broadly supportive of all potential policy solutions identified below.

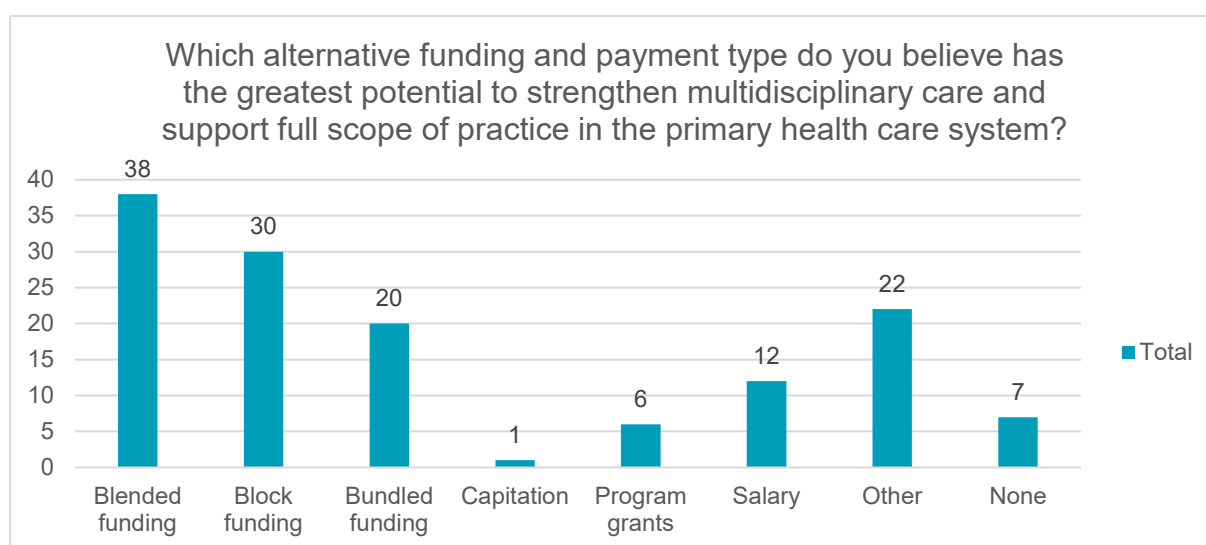
5.5.2.1 Using block, bundled and blended funding to deliver care flexibly

Participants were overwhelmingly in support of alternative mechanisms to deliver funding more flexibly to primary health care services, and there was a near-unanimous view that fee-for-service funding alone is not appropriate to sufficiently fund primary health care services. Fee-for-service funding was viewed particularly by many non-medical professionals as disincentivising their involvement in primary health care teams (along with other issues such as a lack of parity in MBS pricing – see below policy enablers). Moreover, fee-for-service was repeatedly described as especially inappropriate for funding primary health care beyond MMM categories 4 and over (corresponding to small to medium rural towns, remote and very remote communities).

Participants did not present a clear consensus as to which of these alternative funding solutions would be the priority to pursue, in terms of potential benefits. Rather, it was recognised that different funding types would likely be suitable for different types of care. Participants in the online Citizen Space survey were asked about the funding type they believed had the greatest potential to support full scope and practice and multidisciplinary care. Of the multiple choice options, participants indicated the strongest support for blended funding mechanisms (27.9%) followed by block funding (22.1%). Salaried and bundled funding were also supported by 14.7% and 8.8% of respondents respectively.

There was very low support for capitation, with only one respondent selecting this as the preferred choice and many free-text responses indicating a concern about the impact they believed capitation would have on primary health care. Those who selected 'none' generally did not elaborate on why they believed this to be the case, while those who selected 'other' generally supported a combination of funding types, or expressed a preference for other funding policies over this one (see below). Free text-responses to a separate question about how funding would be provided differently to enhance scope of practice aligned broadly with the below quantitative responses, with many participants further expressing support for increases to quantum of Medicare rebates or Practice Incentive Payments (outside the remit of this review).

Figure 44: Response to Citizen Space survey question about alternative funding and payment types



Across consultation, it was broadly agreed that a block funding component (whether alone or as part of a bundled or blended package) could bring myriad benefits, including:

- Allowing primary health services to better meet complex care needs (and therefore work closer to their full scope), since introducing an additional funding stream could reduce reliance on highly episodic care and would better incentivise longer consultations
- Enhancing continuity of care, such as in specific instances where bundled funding could ‘follow’ the consumer across a defined care pathway
- Enabling more flexibility over the makeup of the health care team, such as block funded or salaried health professionals such as nurses, nurse practitioners, non-dispensing pharmacists, and allied health professionals.
- Through the inclusion of multiple disciplines within a care environment (as above), promoting collaborative approaches to care and enabling individual and collective working to full scope of practice, thereby enhancing employee satisfaction and retention.

Support for blended and bundled funding was expressed particularly strongly by representatives of midwifery, specifically in relation to midwifery continuity of care models. Many raised the best practice example of the New Zealand model of midwifery, which provides bundled funding to the parent to use across services. Bundled funding was by its proponents seen as a way of paying for the full scope of health professionals’ skills and competency; however, a minority of respondents observed a risk of overservicing or “coercion to submit to components of the bundle” [Response 112]. Meanwhile, while the principle of My Medicare was supported by most participants, it was generally agreed this was not sufficient to drive the change required to funding policy to enable health professionals to work to full scope.

A range of other alternative funding models were subject to some discussion. Value-based or activity-based funding, while not identified specifically as a proposed policy solution, were the subject of some discussion and disagreement – some supported these models in principle, while others identified risks of narrowly focusing on short-term quantifiable outcomes, which would not be applicable to all instances of care. Delegated funding was also discussed by a smaller number of participants, but was subject to some disagreement; some proposed it was a useful alternative to capture team-based care referrals, and is already in use in some professions (e.g. sonographers), while others believed it would likely be exploited by some primary health care providers.

Examples of the above strategies working to support multidisciplinary teams in practice were shared by participants, particularly those who work in regional contexts. For instance, a Tasmanian after-hours nurse-led service is partially funded by the state government to enable salaried staff, including a community paramedic, while the nurse practitioner continues to bill via the MBS. Other examples highlighted the fact that current MBS billing rules disincentivise delivery of primary health care by some health professions. For instance, one participant observed that a nurse providing rheumatic heart disease nursing in an Aboriginal Community Controlled Health Organisation (ACCHO) context would not attract MBS funding, such that there would be no incentive to employ them over a GP. One survey participant summarised the views of many in stating that ACCHOs represented a good

practice example in terms of billing arrangements, but warned about the associated administrative burden:

There could be opportunity for the health sector to move more towards a mix of bundled and salaried models, with fee-for-service being reserved for some health services where appropriate. More inspiration could be taken from models adopted in Aboriginal Community Controlled Health Organisations (ACCHOs) which address wraparound care needs and often utilise combined salaried models and Medicare billing. However, caution should be taken to not create considerable administrative complexity and reporting burden when combining funding streams. [Response 119]

There was strong support for a range of alternative funding mechanisms, particularly those that contained a block funding component, as a complement to fee-for-service payments which were broadly seen as restricting scope.

5.5.2.2 Funding and payment types which incentivise working as multidisciplinary care teams

This was supported in principle by most participants, who overall recognised the benefit of multidisciplinary care and its potential impact on scope of practice (although there was divergence in what participants understood multidisciplinary team-based care to be – see 5.3 *Employer practices and settings*). There was not a clear consensus reached about what types of funding or payment types would best incentivise working as multidisciplinary care teams. However, it was broadly agreed that policy reform in this area would be well complemented by policies to introduce more block, blended and bundled funding mechanisms (see above) and greater parity in MBS billing (see below).

Specific funding and payment types which were thought to benefit multidisciplinary team-based care were raised by participants. Across participants, the strongest support was for payments for non-patient consultation time, i.e. payment for care coordination and advice, which was emphasised to incentivise greater collaboration with health professionals outside their own practice. Other participants raised ideas for innovative funding models which could sit across multiple health services, such as where all members of the multidisciplinary care team would be required to claim for the funding to be released.

However, many viewed the concept of multi-health service funding mechanisms (i.e. a multi-site multidisciplinary care team being funded for the care of one individual) as inherently complex and in this sense, potentially carrying a high barrier to entry. Some participants raised the concept of care which ‘follows the consumer’, as in the example of NDIS and aged care funding under new system reforms. However, this was not unanimously supported due to the onus this may place on the consumer to navigate the complex primary health care system, and perceptions that this had not been effectively implemented in other adjacent systems.

Participants also shared views about existing funding mechanisms which they viewed as inadequate to meaningfully support multidisciplinary team-based care. Some discussion was held about Workforce Incentive Payments (WIP) intended to increase employment of nurses and other non-medical health professionals in general practices. Experiences were shared where these payments accepted by general practices were unable to flow through to allied

health providers in the region, who typically were employed by small private services, and unable to benefit from the WIP. Meanwhile, several participants across different professions raised that MBS items for multi-professional consultations were complex to claim. Others (including from a consumer perspective) raised that these item codes could be overly prescriptive in some instances, by stipulating a minimum of three health professionals must take part.

Participants expressed strong support for the principle of multidisciplinary care teams, and raised a number of potential funding models they saw as incentivising team-based care, particularly payment for advice or care coordination.

5.5.2.3 Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules

This policy solution was overall viewed as a primary example of unlocking a competency that most health professionals working in primary health care already possess. A question in the online Citizen Space survey asked participants what they saw as the key barriers to health professionals' authority to make referrals across professions. The majority of responses identified MBS funding as the primary barrier, alongside other factors such as lack of clear protocols or pathways, lack of supporting digital systems, and lack of interprofessional understanding and trust.

Although improving referral pathways was seen as a firm priority by many participants, this policy solution was also divisive. It was strongly supported by most non-medical professionals as a means of both enabling the consumer to access MBS benefits for the referred service, and ensuring the referral would be respected by the destination provider. It was also raised that by having the ability to refer to other services (such as specialists and imaging) when required, health professionals would be demonstrating an understanding of their scope of practice (and notably, its limits). A submission from a professional association further noted the potential for physiotherapist referral (for example to orthopaedic surgeons and diagnostic imaging) to create substantial improvements in patient journey as well as economic efficiencies. This submission put forward the view that direct referral authority should be limited to Ahpra-regulated professions for reasons of patient safety, whereas others supported referral authority as being broader (i.e. including self-regulated professions).

Participants furthermore discussed a number of potential barriers and challenges to the implementation of this policy solution. One proponent of direct referrals summarised these as:

- Risk that referrals will not be accepted or acted upon by the referee, e.g. a cardiologist accepting a referral from a pharmacist
- Equity in remuneration for both referrer and referee (regardless of the profession of each party – see below for further discussion about single MBS rates for a particular activity)
- Buy-in from governments (Commonwealth, state and territory) in accepting and paying for non-medical referrals. [Response 118]

Divergent views on this policy proposal were raised by many representatives of the medical profession, many of whom saw a risk of fragmentation of care if direct referrals were expanded beyond their own profession. Accountability was also a concern, as summarised by a professional organisation representing rural doctors:

It is important that with changes to scope of practice there is a link to accountability. Currently the referral/requesting of diagnostics is very reliant on a medical practitioner. If the medical practitioner is the only one accountable for the diagnostics ordered and the follow up care, this can lead to issues impacting on inter-professional collaboration and communication. [Email submission 25]

However, this view was largely not shared by medical representatives working in rural and remote areas, who held a pragmatic view of the limitations of service availability in their area. These, and other non-medical professionals with rural and remote experience, emphasised that in light of poor GP availability, direct referrals could carry substantial benefit to the consumer in terms of continuity of care, and that this ought not to be compromised in the interests of role protection.

It was notable that many medical professionals who shared doubts about this policy enabler in principle were more supportive if two conditions were met: with the proviso that only specific types of direct referrals be funded which are relevant to the referring professional's scope of practice, and in the presence of digital solutions which ensure the GP (and potentially other members of the care team) maintain visibility over referral activity. To this end, it was broadly agreed that direct referrals should only be supported by MBS funding rules under specific circumstances and when they are relevant to the health professional's scope of practice. This was further discussed under 5.6 *Technology*, with digital referrals and secure messaging emerging as a key policy priority under that theme.

Enabling non-medical professionals to make direct referrals by changing restrictive MBS funding rules was strongly supported by most representatives of non-medical professions who predicted significant benefits not only to their own ability to work closer to full scope of practice, but also for consumers in terms of access. Support among medical professionals was stronger among those who worked outside of metro settings, notwithstanding some notable risks and mitigations strategies.

5.5.2.4 Funding episodes of care regardless of profession (i.e. a single MBS rate for a particular activity)

Participants across professional boundaries expressed concerns with the lack of parity in current MBS rates across different professions. The lower MBS rates for non-medical professions, and lack of MBS item codes for some professions (such as nurses) were a particular source of frustration. In particular, the effect this disparity had in disincentivising primary health care practices from employing non-medical professionals was a cause of frustration, and hope was expressed that this policy solution could help to enhance their opportunities in primary health care. In this way, this policy solution was seen as potentially leading to an increase in multidisciplinary care teams and collaboration. In particular, it was seen as critical to better value the work that all health professionals do, and fostering greater interprofessional trust and collaboration. There were minority views among non-medical

professionals that the higher level of training among medical professionals warranted a higher MBS rate, but the majority of non-medical professionals viewed a single MBS rate for particular activities as a key priority. Meanwhile, many medical professionals requested more equitable MBS rates with specialist colleagues for particular activities or services.

Less unanimous support for this solution was voiced by medical professionals. Some participants questioned the breadth of activities such a policy would apply to, and expressed concern that it would reduce care to overly episodic activities without recognising the other elements of care medical professionals may provide. For example, while it was broadly recognised that certain highly defined activities could benefit from parity in MBS rates between the various professions who deliver them, particularly vaccination, some GPs warned against including other seemingly episodic activities in this category. An example given was cervical screening, which one GP stated would be delivered with wraparound care to different extents depending on whether it was delivered by a GP or other professional.

There was overall strong support for funding episodes of care regardless of profession (i.e. a single MBS rate for a particular activity) particularly among non-medical professions, with hesitation from some representatives of the medical profession on the basis it may potentially reemphasise episodic care to the detriment of the consumer.

5.5.3 Additional perspectives

Private health insurance was another area where participants wished to see greater reform, and which was broadly described as a gap in Issues Paper 1. Across participants, many were of the view that the presence or lack of private health insurance benefits functioned in almost the same way as public funding mechanisms, in terms of enabling (or not enabling) particular activities. Some participants shared that they would be unwilling to perform particular services if they knew the consumer would be unable to access private health insurance benefits for that service. Many participants were of the view that decisions made by private health insurance companies often appeared arbitrary in nature, for instance the lack of coverage of podiatric surgeries by most private health insurance provider, in contradiction to Government direction on this matter.

Private health insurance providers' approach to assessing risk was of concern to many participants in terms of its likely impact on efforts to enable health professionals to work to full scope of practice. That is, there was a view that private health insurance providers may be unlikely to reflect contemporary policy or practice within their policies, effectively blocking these policies or practices from benefiting consumers. A particular area of concern was the lack of private health insurance coverage for preventative care and wellness, with many policies only covering acute care (often excluding urgent care, therefore disadvantaging residents of regions serviced solely by Urgent Care Centres). There was therefore a recognised need to work with private health insurance providers to ensure insurance policies are updated to reflect any scope of practice changes.

In addition to the above, a number of participants from non-medical professions expressed an opportunity to equalise access to MBS billing/funding. For example, representatives of a multidisciplinary service specialising in primary health care for people experiencing homelessness raised that restrictions on nurse practitioner bulk billing presented significant

barriers to their service delivery. Moreover, some pharmacists spoke in support of MBS billing for services they provide outside of dispensing, outlined in the Community Pharmacy Agreement. Midwives frequently voiced support for a wider period of time where they could access MBS billing, from the current six weeks to a life course approach, including sexual and reproductive health. These examples are illustrative of the continuing role fee-for-service funding would likely play in enabling scope of practice.

More streamlined and equal access to PBS prescribing was also supported. Some professionals spoke about their inability to prescribe medicines as PBS-subsidised scripts, for example endorsed podiatrists working with diabetic foot presentations requiring antibiotics. In this instance the podiatrist would be limited to providing a private prescription, creating confusion and potentially financial barriers for consumers. Pharmacists also expressed frustration at their profession's inability to perform therapeutic substitution in cases of medicine shortages (e.g. dispensing an equal dose at a different dosage, if one product is out of stock) without involving the GP. Representatives of some pharmacy peak bodies spoke in favour of co-payments for PBS prescriptions, but this view was not reflected elsewhere.

5.5.4 Key areas of crossover with other themes

Legislation and regulation: Funding was seen as the essential tool which allows legislation and regulation to flow through to practice, together setting the authorising environment which facilitates full scope of practice. In this sense, there was a high degree of interdependence between these themes, and the view was very strongly voiced that without corresponding funding mechanisms, legislative and regulatory change would be unlikely to make significant impact on health professionals' ability to work to their full scope.

Employer practices and settings: The relationship between funding policy and employer-level practices was seen as operating in two directions. Funding policy was viewed by many as the key incentive to promoting certain types of care, and that from a sustainability perspective, services would by and large deliver only the services which they were funded to provide. The above funding policies were therefore seen as fundamental to incentivising individual employers to support their teams to work to full scope of practice, and to construct more multidisciplinary collaborative teams. At the same time, individual employer practices could be a barrier in practice to efforts to enable scope of practice using funding levers. Moreover, many spoke of the risk of funding policies offering perverse incentives to individual health services or providers, who may choose to accept in bad faith funding streams intended to enhance scope of practice.

Technology: A digital solution to underpin expanded referrals was agreed to be a critical dependency, and participants emphasised the need for improved digital visibility over the multidisciplinary care team as a way of ensuring funding policy could be implemented in practice.

Education and training: There was significant discussion about the need to appropriately fund education and training, including having dedicated funded pathways for post-

professional entry training and more financial support for health professionals to access ongoing training.

5.6 Technology

5.6.1 Stakeholder views about the policy problem

Stakeholders were asked to respond to the following policy problem, and potential enablers to address this problem.

Robust digital health infrastructure may enable consumers and health professionals to access and share information, and to work together more collaboratively and equitably, by ensuring all health professionals have visibility over the same information. Modernising data and digital technology is a key government reform direction, but key gaps in current primary care IT systems, infrastructure and adoption remain.

Potential enablers include:

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

Participants broadly supported the concept of digital strategies to facilitate health professionals working to full scope of practice. However, it was frequently emphasised that technology enablement remains a tool to drive different aspects of the primary health care system to work together more effectively or efficiently, rather than directly enabling full scope of practice. For example, participants discussed how technology could support interprofessional trust by allowing more visibility over the activities of other health professionals, but would unlikely to generate interprofessional trust in the first instance. It is therefore important to consider how other strategies to drive interprofessional trust, understanding and respect, in addition to a legislative and funding authorising environment, are key dependencies for technology-based policy solutions. As one survey respondent summarised, technology “is a useful adjunct but cannot solve the problem in isolation” [Response 96].

Participants in the online Citizen Space survey were asked about risks and mitigation strategies for technology-based policies to improve scope of practice. Participants emphasised inequitable access due to system rules (where certain professions are blocked from accessing patient records), health literacy challenges, overreliance of telehealth models at expense of face-to-face consultation or learning, and risk of privacy breaches. Mitigation strategies identified included multi-factor authentication, access protocols and other security strategies, support for less-connected consumers and populations, patient opt-out on information sharing and increasing availability of portable devices amongst healthcare professionals. There was overall a view that strengthening existing patient data systems would itself mitigate risks around data quality and consistency, however, a subset of survey

respondents were of the view that technology solutions should not be wholly relied upon due to the risk of outages or loss of access (particularly in rural and remote areas), and the need for backup systems to be in place.

5.6.2 Level of support and consensus for potential policy solutions

5.6.2.1 Establishing access to real-time patient information

This was supported in theory by nearly all participants. The key benefit of real time patient information as described by participants was support for interprofessional trust, because it would provide a single source of truth and visibility over other health professional-led care episodes and patient notes. However, real-time patient information was not in itself seen as generating trust, which would need to be supported by leadership and culture to have a meaningful effect on scope of practice according to most participants.

Participants discussed at length the capacity of the current My Health Record system to enable real-time patient information; there was unanimous agreement that this does not yet exist in a meaningful sense in the primary health care system. Representatives of a number of professions, including pharmacists, midwives, and some self-regulated professions, critiqued the fact that they are unable to upload information into My Health Record under current rules. Furthermore, participants across disciplines described the upload of data into My Health Record as highly inconsistent and existing data quality as generally low, and stated there was a need for more user features such as a summary update view. In its current form, My Health Record Participants further remarked that state and territory-specific single patient records, such as in NSW and ACT, exclude the vast majority of primary health services. It was also remarked that service-specific patient records are typically not interoperable, precluding visibility over other members of the primary care health team.

In light of these challenges, participants recognised the complexity of reforming the current patient information systems to the extent needed to allow genuine real-time patient information. Some expressed cynicism that a genuinely useful real-time patient information system or repository could ever be implemented, given perceived failings of the My Health Record. Moreover, participants particularly from a consumer perspective were wary of policy solutions which involved or resembled mandatory upload of information, although this was supported by some health professionals across multiple disciplines. Some consumers discussed how privacy and data security concerns would have to be weighed against the benefits (in terms of continuity of care, quality and safety) which could be achieved through a single patient view. Moreover, a minority of participants highlighted a potential risk where the availability of real-time data may reduce health professionals' willingness to communicate directly with one another.

Establishing access to real-time patient information was supported nearly unanimously in principle, but significant reservations about its feasibility were voiced across consultation. Expanded access to My Health Record was strongly supported.

5.6.2.2 Introducing platforms for secure messaging and digital referrals

In comparison to the above proposed solution, secure messaging and digital referral platforms were seen as more feasible to implement within primary care health teams sitting across multiple services. Both services were overall supported as critical to underpin multidisciplinary care teams, reducing dependence on unreliable paper- and fax-based systems and enabling visibility over and trust between professions. Many participants expressed views that in a time-poor clinical environment, there were significant communication barriers between services (e.g. through telephone consultations) which could be better managed by secure messaging services. In this way, secure messaging could enable more multidisciplinary collaboration and enable health teams to work together differently to full scope. Participants who worked in clinical practice reported that these systems, where in place, worked well; some expressed surprise that they were not more widespread.

In particular, a digital mechanism underpinning referrals was viewed as a critical underpinning if the authorising environment were to change to expand referrals beyond GPs (i.e. through change to funding policy). This was strongly supported by many representatives of health professions which stood to gain further referral authorities, as a way of streamlining the referral process and facilitating connection and collaboration with the destination service. As discussed in 5.5 *Funding policy*, many GPs questioned the premise of expanding referrals and anticipated a risk of fragmentation of primary health care system; however, many of these GPs viewed a digital referral system as mitigating part of this risk, provided they retained visibility over the consumer's care. In this way, visibility, trust and willingness to share responsibility over care were also linked.

Complexity around implementation was raised as a potential risk, in that the primary health care landscape is highly dispersed between separate private providers using digital systems provided by different vendors. Participants across multiple professions raised that cost of vendor solutions was a significant barrier to onboarding new software. Moreover, primary health care professionals reported that they are required to install multiple software solutions in order to interface with multiple services, which is particularly prohibitive in terms of cost – for instance, an allied health professional receiving referrals from multiple different GP practices would currently need to install each of their respective secure messaging software in order to receive or reciprocate their messages. Participants emphasised that scaling up use of digital referrals or secure messaging software should seek to move away from this status quo.

Introducing platforms for secure messaging and digital referrals was supported as a more feasible means of enhancing visibility over other members of the care team and a key dependency for other policy proposals (such as expanded direct referrals and incentivising multidisciplinary care teams), but participants warned against a proliferation of software which was seen as having little impact on practice.

5.6.2.3 Using decision support software

Significant discussion was held over whether decision support software was a legitimate means of enabling health professionals to work to full scope. On one hand, participants

raised some examples of decision support software (or similar software) helping to make clinical decision-making more efficient, or enhancing visibility of relevant patient information (related to discussion of the benefits of real-time patient information, above). However, decision support software was overall not supported as a means of expanding scope of practice, as participants pointed out an activity or decision would need to already be within a health professional's scope of practice for these tools to be used safely. In summarising this, one GP made a distinction between warnings or alerts, which they viewed as useful, compared with decision support software which they saw as implying a less active role.

The risks of overreliance on decision support software, particularly AI, were frequently raised; these risks were seen as heightened where an activity or decision was less familiar to a health professional. Participants across multiple jurisdictions further reported that non-digital decision support tools, such as Health Pathways or the CARPA framework in the Northern Territory, were equally useful to software solutions, and could be effectively rolled out to support consistency of scope across primary health care systems. Representatives of allied health professions expressed that there was an opportunity to better embed allied health professions into these pathways.

Decision support software was not broadly supported as a means of safely expanding scope of practice, compared to existing decision support tools, but was seen as a potential means of improving efficiency.

5.6.2.4 Mandating participation in a multidisciplinary care team for primary care providers

Participants were broadly in support of multidisciplinary care teams as a means of enabling full scope of practice, although there was a lack of consensus how this would best be achieved (GP-led teams, or teams coordinated differently depending on the needs of the consumer). Participants largely did not support the concept of mandating participation in multidisciplinary care teams, on the basis that this mandate would be burdensome to meet in practice, possibly reduce flexibility to form teams based around individual consumers' needs, and the potential for overservicing in some cases. Numerous participants also questioned how such a mandate could be achieved, and how the digital mechanism for doing so would function. Overall, participants were not of the view that any such digital mechanism would enhance their ability to work to full scope of practice.

Recognising the intent of this policy solution was to encourage team-based collaborative care, many participants suggested other types of incentives to form multidisciplinary care teams would be useful. The predominantly supported strategy was funding policy solutions to incentivise collaboration (see *5.5 Funding policy*). Moreover, technology solutions to facilitate information sharing and communication across multidisciplinary care teams were strongly supported (see above), notwithstanding known challenges in achieving and maintaining interoperability across multi-site care teams. These were seen as more direct means of enabling individual and teams of health professionals to work together to full scope of practice.

Mandating participation in a multidisciplinary care team for primary care providers was not strongly supported due to the mandate element, but most were supportive of the underlying principle albeit achieved through other policy levers such as funding policy, education and training, and employer support.

5.6.3 Additional perspectives

Telehealth emerged from consultations as a key enabler of full scope of practice, while not raised as a standalone policy solution in Issues Paper 1. Participants spoke about COVID-era shifts towards remote health capabilities, and broader Government reform in this direction. Enabling more widespread use of telehealth had strong support across professional lines as a way of supporting team members to work to their respective full scopes by offering virtual supervision or support. This was particularly supported by representatives of rural primary health, who had experience in using telehealth technologies to provide health care over large distances and in remote areas.

The use of telehealth connections to facilitate multidisciplinary care teams was also discussed, such as in providing a virtual space to collaborate and/or provide care to the same consumer simultaneously across multiple sites. However, it was frequently raised that bandwidth issues in many areas of Australia may prevent telehealth from being used effectively, and that it should not therefore be completely relied upon for primary health care delivery. By the same token, reliance on telehealth for support or supervision (e.g. of a nurse or assistant) would carry a dependency on telecommunications connectivity for that health professional to work safely to their full scope. As one survey respondent from a remote midwifery background summarised: “telehealth is absolutely not the answer and should not be used for a substitute for face to face care” [Response 79].

In line with hesitancy over digital decision support software, enthusiasm was balanced with some concerns over the increasing appetite for artificial intelligence (AI) in primary health care settings. Participants warned against solutions which relied on AI at the expense of clinical judgment. However, AI was broadly viewed as a potential avenue for reducing the administrative burden on primary health care professionals, potentially having an indirect impact on scope of practice as health professional time is freed up for patient-facing work. For instance, AI summaries of session notes (as in a recent ANZACATA trial of an AI-assisted case notes app), referrals and report writing (e.g. facilitated by voice-to-text). The need for clear standards of use, as well as incorporation into education and training programs, were raised as ways of mitigating potential risks.

5.6.4 Key areas of crossover with other themes

There was a significant level of crossover between Technology and other themes, which was bidirectional (both in terms of other policy solutions being necessary to promote best use of technology solutions, and technology acting as an enabler to other policy solutions).

Funding policy: Funding policy was broadly seen as a critical dependency for any technology-based policy solution to reach its full potential, in that it was a core element of the overall authorising environment. For example, participants shared that digital referral software would be best capitalised upon by underlying funding policy that facilitates broader referrals by non-medical professions, and technology solutions aimed at facilitating multidisciplinary collaboration would complement funding streams to support multidisciplinary team-based care delivery. Moreover, participants wanted to see specific funding streams to support digital implementation.

Legislation and regulation: Like funding policy, legislation and regulation was discussed as fundamental to set the overall authorising environment under which health professionals, and multidisciplinary care teams, would work. Conversely, if legislation and regulation were to change to authorise additional activities for a particular health profession, technology enablement would have to be considered to facilitate this in practice (for example, access to dispensing or prescribing software in the case of changes to Drugs and Poisons legislation).

Employer practices and settings: Participants discussed how leadership within individual services was responsible for the level of uptake of technology solutions. Those who did not set a culture of willingness to adapt to new digital solutions were more likely to be reliant on paper, fax or phone-based coordination of care, and health professionals within those services could experience barriers to their scope of practice as a result.

Education and training: The relationship with education and training was discussed in both directions. Technology was viewed as a key avenue for enhancing access to post-professional entry education and training, although some held a view that certain skills (such as interprofessional skills) would be better taught using face-to-face methods. Meanwhile, the need for targeted upskilling to support uptake of digital solutions was discussed widely; for instance, in supporting consistency of patient information recording and uploading into digital systems, many participants saw an opportunity for education and training across the system. It was also raised that undergraduate education should expose trainees to the types of technologies they would be likely to encounter in primary health care settings.

Conclusion

Across the policy areas, there was general consensus reached that the policy solutions raised were acceptable and would likely support health professionals in working to their full scope of practice, albeit with some areas of divergence largely across health professional lines. Moreover, working together to full scope of practice, as multidisciplinary care teams, was overall a common goal for the majority of participants. In many instances, the concept of working collectively and collaboratively to full scope was essential to complement individual capacity to work to full scope of practice; in some cases, this mitigated concerns about the perception that scope of practice would be 'expanded'.

Participants warned that practical change would need to occur on the basis of this review in order for it to have a lasting impact on the primary health care landscape. Nonetheless, there was hope and optimism expressed that reform was possible to authorise and enable all health professionals to do everything they were trained, competent and qualified to do.

Appendix A: Summary of Phase 2 consultations

The below table summarises face-to-face and online consultations held during Phase 2 consultations.

Each session had a maximum of 30 participants. A total of 486 participants took part across the 21 total consultations. Note that upcoming online consultations scheduled for 26 March 2024 (tailored consultations with Consumers and First Nations) have not been included in the below table.

Table 2: Summary of Phase 2 in-person consultation

Type	Location	Date	Number of sessions
Face-to-face consultation	Canberra	7 February 2024	2
Face-to-face consultation	Sydney	8 February 2024	3
Face-to-face consultation	Brisbane	9 February 2024	3
Face-to-face consultation	Melbourne	13 February 2024	3
Face-to-face consultation	Launceston	14 February 2024	1
Face-to-face consultation	Hobart	14 February 2024	1
Face-to-face consultation	Adelaide	20 February 2024	2
Face-to-face consultation	Perth	22 February 2024	2
Face-to-face consultation	Darwin	27 February 2024	2
Online consultation	Rural and remote	4 March 2024	2

Appendix B: Summary of Phase 2 survey responses

The following tables summarise distribution of Citizen Space survey respondents across participant demographics.

Table 3: Distribution of Citizen Space survey respondents – Individual

Individual Category Distribution	% of all responses
Health Professional/Worker	50.93%
Educator	6.21%
Other	4.35%
Total	67.08%

Table 4: Distribution of Citizen Space survey respondents – Organisational

Individual Category Distribution	% of all responses
Health Service	3.11%
Peak Body	9.94%
Government	1.86%
Regulator	3.11%
Professional Association	8.07%
Other	6.83%
Total	32.92%

The following table summarises response rates for each of the online survey questions. A total of 161 responses to the survey were received.

Table 5: Phase 2 Citizen Space survey response rates per question

Theme	Question no.	Question text	No. responses	Response rate
Funding policy	1	What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently.)	148	91.9%
Funding policy	2	A risk-based approach to regulation names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than relying solely on named professions or protected titles. To what extent do you think a risk-based approach is useful to regulate scope of practice?	111	68.9%
Funding policy	3	Please provide any additional comments you have on the risk-based approach to regulation.	137	85.1%
Funding policy	4	What do you see as the key barriers to health professionals' authority to make referrals across professions?	142	88.2%
Employer practices and settings	5	What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)	142	88.2%
Employer practices and settings	6	Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?	130	80.7%

Theme	Question no.	Question text	No. responses	Response rate
Employer practices and settings	7	What can employers do to ensure multidisciplinary care teams are better supported at the employer level, in terms of specific workplace policies, procedures, or practices?	133	82.6%
Education and training	8	What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope? You may select multiple responses. ³	157	97.5%
Education and training	9	If you chose 'other', please provide details.	98	60.9%
Education and training	10	To what extent do you think health professionals' competencies, including additional skills, endorsements or advanced practice, are recognised in their everyday practice and are known to consumers?	154	95.7%
Education and training	11	How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?	135	83.9%
Funding policy	12	Are you aware of specific instances where funding and payment could be provided differently to enhance health professionals' ability to work to full scope of practice? Please provide specific examples.	135	83.9%
Funding policy	13	Which alternative funding and payment type do you believe has the greatest potential to strengthen multidisciplinary care and support full scope of practice in the primary health care system?	136	84.5%

³ Note: An error in wording of Question 8, which referred to a non-existent option to select multiple responses, means that the responses to this question were considered invalid. The most popular response was 'Other' with most of these respondents to the follow-up Question 9 using the free text response to list their intention to select multiple responses to Question 8.

Theme	Question no.	Question text	No. responses	Response rate
Funding policy	14	How do you believe your selected funding type(s) could work to resolve barriers to health professionals working to full scope of practice?	118	73.3%
Funding policy	15	To what extent do you believe alternative funding policy approaches create risks or unintended consequences?	134	83.2%
Funding policy	16	How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?	116	72.0%
Technology	17	How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?	133	82.6%
Technology	18	If existing digital health infrastructure were to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?	121	75.2%
Technology	19	What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?	116	72.0%

