

Unleashing the Potential of our Health Workforce

Scope of Practice Review

Stakeholder Engagement Report 2

2 September 2024

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1 Executive summary

This report summarises key insights from Phase 3 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 from April to June 2024, consisting of:

- A program of in-person round table consultations (183 participants across seven consultation sessions), held from 11 to 26 June 2024. Consultation included key sector stakeholders, and dedicated sessions were held with representatives of the Review Executive Advisory Committee and representatives of the rural and remote health workforce community;
- Targeted online consultation with consumers (26 participants in one consultation), First Nations (9 participants in one consultation spread across two sessions) and rural and remote stakeholders (17 participants in one consultation), held from 17 to 28 June 2024, for a total of 52 participants;
- An online survey published on a public online platform (Citizen Space platform), open between 18 April 2024 and 24 May 2024 (receiving 120 written submissions)
- Receipt of email submissions (32 received on or prior to 31 May 2024).

In both consultations (in-person and online) and the Citizen Space survey, stakeholders were asked to respond to questions about eight options for reform as outlined in Issues Paper 2. Participants in the online survey were invited to respond to a total of 16 questions across the eight reform options (as well as overall views about the value and direction of the Review), adapted for an online context.

A wide range of stakeholders including health professionals, employers, funders, governments and consumers attended the consultations and provided written submissions, the majority representing health professions (practicing and/or representing professional organisations and peak bodies).

Stakeholder views were examined for the relative level of support presented across each of the proposed reform options; implementation insights, and key areas of convergence, divergence and interdependency, as well as for emerging insights which did not appear in Issues Paper 2. 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 reform options explored in Issues Paper 2, as well as 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 the Citizen Space platform.

Table 1: Summary of Stakeholder Engagement Report 2 findings

Theme	Key Finding / Reform Option	Description
Cross-cutting theme	Overarching views on direction and scope of Review	<ul style="list-style-type: none"> General support for the overall reform direction, contingent on implementation considerations and effective change management processes.
Cross-cutting theme	Leadership, culture and governance	<ul style="list-style-type: none"> Governments, professional organisations, education providers, consumers, regulatory organisations and health services all emphasised as key players, and working together as a priority. Recognition of community need as a driver of reform. Collaboration between all members of the care team through a non-hierarchical approach and commitment to a clear reform vision. Cultural change required to transform primary health care, challenging entrenched power dynamics. Evaluation and monitoring of the outcomes of reform viewed as important to ensure the goals of reform are achieved while maintaining consumer safety and quality care.
Cross-cutting theme	Clinical governance	<ul style="list-style-type: none"> Effective clinical governance is a critical enabler for safe and effective implementation. Potential expanded role for government in supporting clinical governance in the primary health care sector.
Cross-cutting theme	First Nations voices	<ul style="list-style-type: none"> Stakeholders representing the First Nations health sector were generally supportive of the intent of the review in seeking to strengthen multidisciplinary team-based care, and reiterated the message that this reflected the way primary health care is delivered effectively in ACCHO settings. Stakeholders warned against perceived assumptions the ACCHO model could be 'scaled up' in absence of the specific

Theme	Key Finding / Reform Option	Description
		governance mechanisms, the local context and cultural underpinnings of this model.
Cross-cutting theme	Consumer voices	<ul style="list-style-type: none"> • Consumers were primarily concerned with issues which have a material impact on their experience accessing primary health care, including consumer choice, affordability and accessibility of health services. • Consumers urged that people with lived and living experience should have a critical role in informing the development of all reform options.
Workforce design, development and planning	1. Skills and Capability Matrix and Framework	<ul style="list-style-type: none"> • Stakeholders indicated general support for this reform as providing a foundation for skills-based primary care and interprofessional trust. • A transparent, inclusive approach should be taken to develop the Matrix. • The Matrix could be useful to a range of stakeholders in meeting community need. • It is essential the Matrix is dynamic and accessible.
Workforce design, development and planning	2. Develop primary health care capability	<ul style="list-style-type: none"> • This reform received a high level of support from the majority of stakeholders who recognised the need to improve the perceived value of primary care specific education and training. • Provision of quality supervised practical training (or 'placement') opportunities in primary care was viewed almost universally by stakeholders as critical. • Addressing existing barriers to the provision of quality placement experiences in primary care was viewed as critical. • Establishing a skilled and valued supervisor workforce was viewed as essential to quality training experiences in primary care. • Mandating supervised practical training in primary care, although acknowledged as a potential contributor to reform, was considered unachievable and not favoured.

Theme	Key Finding / Reform Option	Description
		<ul style="list-style-type: none"> The development of collaborative skills (through interprofessional education and other collaborative experiences) was viewed as a foundational expectation for all health professionals.
Workforce design, development and planning	3. Early career and ongoing professional development includes multi-professional learning and practice	<ul style="list-style-type: none"> Universal support to provide health professionals who work in primary health care with the resources to maintain and enhance their skills. Access to affordable, modular education and training to support development and maintenance of primary care skills and capabilities considered critical. High level of support for the establishment of greater consistency and availability of mentorship and peer support and/or coaching across the career continuum. Stakeholders viewed multiprofessional learning as important to developing the multidisciplinary team, but expressed opposition to this being mandated as part of continuing professional development programs instead preferring it to be incentivised.
Legislation and regulation	4. Risk-based approach to regulating scope of practice to complement protection of title approach	<ul style="list-style-type: none"> Overall support voiced for this reform option, contingent on it being a complement to, rather than replacing, protection of title. Stakeholders preferred 'activity-based' to skills-based regulation and a focus on community need rather than solely on high-risk activities. Some stakeholder groups raised concern about a perception that activity-based regulation could be reductive in treating primary care as a collection of defined activities, and in being silent on areas of primary care outside of these activities, may unintentionally devalue some of the work primary health care professionals do.

Theme	Key Finding / Reform Option	Description
		<ul style="list-style-type: none"> Need to reinforce and strengthen clinical governance arrangements to promote safety and quality of care.
Legislation and regulation	5. Independent, evidence-based assessment of innovation and change in health workforce models	<ul style="list-style-type: none"> High level of support and enthusiasm for this reform option, as filling a critical gap in supporting health workforce reform in the primary health care system. Overall consensus that this mechanism should not be housed within Ahpra, but should be national in order to hold an overarching role across professions. Should be broadly representative and non-hierarchical to avoid driving specific agendas.
Legislation and regulation	6. Harmonised Drugs and Poisons regulation to support a dynamic health system	<ul style="list-style-type: none"> Overall strong support for this reform option voiced across professional groups despite the perceived implementation challenges. Many participants supported a staged approach to harmonisation that commenced with relatively lower-stakes consensus-building activities. Strong support for additional harmonisation efforts including radiation safety.
Funding policy	7. Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice	<ul style="list-style-type: none"> Broadly positive response to the concept of moving towards a blended payment model in primary health care, provided it has a well-designed and realistic risk stratification mechanism. Representatives of allied health professions raised concerns about the lack of a specific mechanism for funding availability and transfer outside the consumer's main general practice. Mixed support for a single payment rate for like services provided by a range of professions. Difficult to isolate the specific service provided from the context of the broader clinical encounter, and different skill sets of providers.

Theme	Key Finding / Reform Option	Description
		<ul style="list-style-type: none"> Broad consensus that a bundled payment for midwifery continuity of care maternity service model would be of significant value in resolving scope of practice issues specific to this workforce. There are opportunities to expand into other condition or treatment pathways such as diabetes care.
Funding policy	8. Direct referral pathways supported by technology	<ul style="list-style-type: none"> Significant support from both consumers and non-medical professions on the basis it would address scope of practice issues and improve access. Mixed support from medical professionals due to concerns about the potential for fragmented or episodic care. Broad agreement that an instant notification and communication mechanism was crucial to maintain care integration across the multidisciplinary team and ensure the safety and effectiveness of this reform option for consumers.

2 Introduction

This section provides the background and context to the Scope of Practice Review, and sets out the focus of Phase 3 consultation in the context of previous review consultation phases and their respective areas of focus.

2.1 Background

The Strengthening Medicare Taskforce¹ began work in July 2022 to provide concrete recommendations to the Australian Government in relation to improving patient access to primary health care.

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

- increasing access to primary care
- encouraging multidisciplinary team-based care
- modernising primary care
- supporting change management and cultural change.

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

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

Professor Mark Cormack is leading this intensive, independent review. Titled 'Unleashing the Potential of our Health Workforce', the Scope of Practice Review, is reviewing current models of care in the context of community needs. The review is being conducted in four phases between September 2023 and October 2024. The current period of consultation forms part of Phase Three 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.

The review is examining the following focus areas for opportunities and lessons learned:

¹ Australian Government (2022) [Strengthening Medicare Taskforce Report](#), DOHAC website, accessed 1 August 2024.

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

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 Three consultation

The Review seeks to conduct broad consultation over the four phases to hear and consider all relevant perspectives and voices. The focus areas of consultation phases adapted in response to iterative review findings.

- During Phase One of the review, public consultation was undertaken focusing on the benefits, risks, barriers and enablers of health professionals working to full scope of practice. This phase of consultation yielded in excess of 700 submissions from a wide range of stakeholders. The findings of this consultation were provided in Issues Paper 1.
- During Phase Two, public consultation was sought in response to five focus areas: legislation and regulation, funding and payment policy, education and training, employer practices and settings, and technology. Public consultation consisted of a program of in-person round table consultations (486 participants across 19 consultation sessions); online consultation sessions targeting consumers, rural and remote, and First Nations stakeholders; online survey responses (161 submissions); and email written submissions (75 submissions) provided input into Issues Paper 1. These insights were synthesised in Stakeholder Engagement Report 1 and informed Issues Paper 2.

Phase Three consultation was undertaken throughout June 2024. The consultation process generated feedback from a range of perspectives on the emerging themes raised in Issues Paper 2, and consultation focused on implementation considerations for the eight reform options as set out in Issues Paper 2.

Consultations occurred via:

- a public submissions portal (the Citizen Space portal), receiving a total of 120 submissions;
- written submissions provided via email in response to the Scope of Practice Review request for submission, receiving a total of 69 submissions;
- seven face-to-face consultation sessions held across Australia, one targeted virtual session for First Nations health sector stakeholders held across two sessions, one virtual session for consumer stakeholders, and one virtual session for rural and remote stakeholders; collectively, these were attended by 235 participants.

The eight reform options as presented in Issues Paper 2 formed the basis of consultation feedback and analysis. The primary focus of consultation was the implementation considerations for these reform options:

1. National Skills and Capability Framework and Matrix
2. Develop primary health care capability (strengthened visibility of primary care in entry-level curriculum; support for Supervised Practical Training; strengthened interprofessional education)
3. Early career and ongoing professional development includes multi-professional learning and practice (support for post-qualification education and training; support for supervision and mentoring; multiprofessional learning)
4. Risk-based approach to regulating scope of practice to complement protection of title approach
5. Independent, evidence-based assessment of innovation and change in health workforce models
6. Harmonised Drugs and Poisons regulation to support a dynamic health system
7. Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice (broad based, risk adjusted blended payment for primary health care; single payment rate for like services within common scope; bundled payment for midwifery continuity of care models)
8. Direct referral pathways supported by technology

2.3 Purpose of this document

This paper summarises the major themes identified during Phase Three consultation.

The analysis builds on the consultation findings obtained during the first two phases of the Review. Together with the findings of the literature review and legislation and regulation review previously prepared as part of this Review, this analysis will contribute to the development of a draft Final Report, 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 Issues Paper 2 was sought using the below mechanisms as outlined in *2.2 Phase Three consultation*.

This phase of consultation focused on stakeholder feedback in response to the eight reform options set out in Issues Paper 2, in particular related to implementation considerations. 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 2 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 responses was conducted where required.

3.2 Limitations

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. To minimise this bias and maximise reliability of analysis, two researchers undertook analysis independently. The analysis was then discussed in detail with the broader analysis team who provided input into the drafting process, to further mitigate the risk of any biases by an individual analyst.

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 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.

The approach to recruitment for the in-person consultations sought to minimise the effect of respondent bias by including representation across a range of health professions, consumer representatives, and other relevant stakeholders; and by seeking the participation of experts who could provide insights from a broader systems perspective.

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 for 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. For the purposes of this review, full scope of practice is defined as: *Professional activities that a health professional is educated (skill / knowledge), competent and authorised to perform, and for which they are accountable.*

The review acknowledges that individual scope is time-sensitive and dynamic and influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority / governance) of the service provider. The review seeks to identify how health professionals can be enabled to work according to their demonstrated competence, and reinforces the importance of

individuals acknowledging and working within personal and professional competence boundaries.

4 Overview of stakeholder consultation

4.1 Overview of in-person and virtual consultations

Ten consultation sessions were conducted (seven in-person, three virtual) from 11 to 28 June 2024. A total of 235 stakeholders participated in the consultation sessions, including health consumers, health professionals, professional organisations, peak bodies, educators, government representatives, 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. Virtual consultations were held with First Nations health sector stakeholders (one consultation spread over two sessions), consumer stakeholders (one consultation) and rural and remote stakeholders (one consultation).

A summary of in-person and virtual consultations is provided in [Appendix A](#).

4.2 Overview of written submissions

A total of 120 survey responses were received through the Citizen Space platform between 18 April 2024 and 26 May 2024. Participants were asked a total of 16 questions. Response rates for each question are provided in [Appendix B](#).

Most responses (58%) were received from individuals, and of these, 77% identified themselves as health professionals. Of the organisational respondents (42%), the majority (64%) were from either peak bodies or professional associations.

Stakeholders were also invited to provide written submissions via email. 32 written submissions received were via email up to a deadline of 31 May 2024, provided on or before 3 June 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 36 written submissions were provided after 31 May 2024 per extensions granted on request. These written submissions are not reflected in this report but will be reviewed and the input considered in the development of the Draft Final Report.

5 Findings and stakeholder themes

This section summarises overarching findings relating across the Review, and stakeholder insights relevant to each of the eight reform options which were the focus of this phase of consultation.

5.1 Overarching findings

5.1.1 Overarching views on direction and scope of Review

- There was general support expressed for the overall reform direction. Stakeholders broadly expressed that the combined reform proposals had value and were likely to achieve the intended aims of the review.
- Where there was general agreement reached about the rationale for particular reform proposals (outlined in greater detail throughout the remainder of this section), stakeholders emphasised that implementation considerations were an important factor influencing their level of support for the reform proposal in practice and highlighted specific considerations for a range of settings.
- The importance of effective and inclusive change management processes was raised frequently as a fundamental requirement for successful implementation of reform options (and the associated leadership and cultural reforms).

5.1.2 Leadership, culture and governance

Leadership

Stakeholders were asked to respond to the following questions about leadership:

What leadership do you consider important to ensure reforms are successfully implemented? For example, what is required at the professional, practice, organisation and/or profession level?

What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a co-operative way to achieve the intent of these policy options? Are there implementation options which have not been considered?

The reforms presented in the second Issues Paper were acknowledged as significant. Successful implementation of the reforms was noted to hinge on effective leadership, which was described by stakeholders using a range of adjectives, including *bold, impartial, inclusive, transformational, open-minded, transparent, courageous, committed, consistent, visionary, innovative, accountable, ethical and strong*.

Stakeholders considered the need for effective leadership across multiple contributors to primary care, including:

- Government. Support was expressed for strong and effective collaboration across all levels of government, and a clear commitment to the proposed reforms from National Cabinet. It was acknowledged that while primary care is the core responsibility of the Australian Government, close collaboration with state and territory governments is critical to achieving measurable outcomes. Broad political support was seen as vital to the

reform agenda, regardless of which party holds power, and viewed as an opportunity for government to demonstrate collaboration and a commitment to progressive reform.

- Professional organisations and peak bodies. Stakeholders acknowledged the importance of primary care professions owning, and advocating for, their role in the reform process. However, collaboration between professions was also identified as a clear priority to achieve change. Professional organisations were seen as significant contributors to change management and the importance of effective leadership and resourcing to support change was noted in this context.
- Education providers. This sector was acknowledged as critical to the planning and preparation of the primary care workforce. Leadership and collaboration across professions was identified as an important contributor to consistent implementation of reforms and to the development of skills important for all health professions, including collaborative skills.
- Consumers. Leadership within consumer advocacy organisations was acknowledged as important to enable a clear understanding of the consumer perspective and the inclusion of this view in the reform process. Consumer respondents indicated a desire for health professionals to co-operate, noting the importance of all primary care professionals 'getting on'. There was a consistent call across stakeholder groups for reforms to contribute to better outcomes for consumers.
- Regulatory organisations. Leadership within and across regulatory organisations, including National Boards and professional organisations for self-regulating professions, was viewed as important to implement reforms.
- Health services. Leadership within health services (i.e. clinical leadership) was identified as important to develop a tailored plan to achieve best practice reforms. This was seen as involving clinicians being empowered to work together to bring about change as part of their everyday work, an important complement to the leadership provided by professional organisations and other key stakeholders listed above.

"A top-down commitment to collaborate with a focus on best outcomes for the community will be required among various stakeholders, including healthcare professionals, policymakers, regulators, and patient advocacy groups. Leadership should foster a collaborative environment where different perspectives are valued, and consensus is built through open dialogue and mutual respect." (Consultation participant, peak organisation perspective)

Stakeholders indicated that effective leadership, in the context of the proposed reforms, would require specific attention to the following:

Consumer and community need. Leadership was noted to require a determined focus on improved consumer and community outcomes as the driver for, and foundation of, all reforms. The importance of this principle was frequently raised and viewed as serving to unite, rather than divide, primary care professions.

"...the siloed, doctor lead health system that is firmly entrenched within the Australian culture will need to be fundamentally shifted with genuine recognition of the central role of the patient/ consumer in health decision making and the importance of a far broader spectrum of specialised health care professionals who must be given the authority to work with the patients/ consumers to drive efficient, timely and effective access to necessary services and support..." (Consultation participant, consumer advocacy organisation perspective)

Recognition of the contribution of each member of the primary care team, which was commonly identified as a critical enabler of the reforms. The importance of **including all stakeholders**, including regulated, self-regulated and unregulated professions, along with consumers, health professionals, professional organisations/peak bodies, regulatory organisations, educators, industry, program administrators (e.g. PHNs, DOHAC), health services and Jobs and Skills Australia in reforms was identified. Stakeholders noted that barriers to health professionals working to full scope of practice can be based on entrenched and outdated perceptions of professional scope. These views were considered unhelpful and a threat to effective reform. Systems and practices that support outdated views were also identified as unproductive. For example, decisions about role delegation should be made with an inclusive approach that respects the views of both the profession who delegates and those to whom roles are delegated, rather than only those who delegate.

Collaboration between all members of the primary care team was viewed as instrumental to reforms. To support this, a co-ordinated and inclusive approach to leadership was considered vital. Removal of hierarchies was highlighted as essential to understanding the potential impact of reforms for all members of the primary care workforce. Stakeholders expressed strong objection to leadership falling to one profession.

*“We need to change the thought that health is owned by one profession but that it is a symbiotic process of changing to the nature of the community health needs.”
(Consultation participant, health professional perspective)*

Stakeholders considered cross professional collaboration in the development of frameworks, policies and guidelines that support reforms, essential to the success of the proposed reforms.

Commitment to a clear, system-level reform vision. The importance of establishing a vision for primary care, and communicating this effectively for all, was frequently raised as essential to achieving effective change. Change was noted to require a system, rather than profession-specific, view of primary care. Many saw the reforms as an opportunity to improve care for all consumers.

Recognised characteristics of effective leadership considered essential for successful reform were noted to include clear communication, transparency, visibility and effective engagement with all stakeholders. These characteristics were considered important to achieve the culture change that will support the proposed reforms.

Culture

A change in culture was seen as both contributing to, and resulting from, effective primary care reforms. Stakeholders expressed a strong and common view that transforming primary care will require a culture change, for some professions, to view primary care as a valid and attractive career path rather than inferior to the acute care sector. To support this change, visible career pathways into primary care are required, beginning with early exposure to the breadth of primary care practice during pre-qualification education and training, and continuing through to supportive supervision, mentorship and peer support programs for health professionals.

Leadership was considered an important catalyst for the necessary culture change to support primary care reform. Effective leaders were viewed as instrumental to generating a culture that embraces a reformed primary system, consistent with a clear and inclusive vision, and

works to achieve change. Stakeholders suggested that reforms should be sustainable to support a lasting change in culture which was considered instrumental to achieving effective reform. Consistent and strong leadership was considered important to this outcome.

Views were explicitly expressed that the review should look beyond the politicisation which they saw as inherent in the dynamics within and between professions and their representative organisations. Many advocated for the review to engage with people working 'on the ground' to mitigate against what was described as 'entrenched order' and 'lobbying power', and to ensure implementation was carried out genuinely in the interests of the health workforce, consumers and communities.

Monitoring reform outcomes

Stakeholders highlighted the importance of monitoring and evaluating the outcomes of reform to ensure the goals of the Review are achieved. The recently released National Wellbeing Framework² was highlighted as providing an opportunity to operationalise values-based primary healthcare and considered by some a useful tool to inform outcomes data relevant to the reforms. A commitment to evaluating reform outcomes was viewed as an important measure of reform accountability.

5.1.3 Clinical governance

Given the breadth of primary care services and the importance of ensuring services deliver care that addresses community needs, stakeholders considered flexibility in clinical governance an important feature of reforms. A commonly expressed view indicated that while national consistency is important in many areas of primary care, there is a parallel need to enable flexibility in the local application of care.

Effective clinical governance was highlighted across submissions as a critical enabler for the safe and effective implementation of all reform options. An appropriate level of clinical governance was also seen as essential for ensuring health professionals were enabled to perform activities to their full scope of practice. Numerous stakeholders called for greater clarity about how the review proposed to support clinical governance.

Clinical governance was seen as a necessity to support reform options to mitigate against the risk of health professionals working beyond their scope of practice. Conversely, the Matrix was seen as supporting good clinical governance by improving clarity around scope of practice and areas of shared practice.

The diffused nature of clinical governance arrangements in primary health care, compared to the acute sector, was raised as a potential issue in the timely implementation of reform options. There were some suggestions there was a stronger role for government in supporting clinical governance due to the varying capacity of smaller primary health care services. Numerous stakeholders raised the view that clinical governance would start from a generally strong basis in rural and remote areas because these local health systems, out of necessity due to workforce scarcity, have had to develop strong local clinical governance arrangements. Stakeholders raised some existing examples of quality standards being limited to specific primary care settings (such as Royal Australian College of General

² Australian Government. The Treasury. *Measuring What Matters*. Accessed 09 August 2024.

Practice standards and the Australian Community Pharmacy Standard) which would need to be considered in the application of any new broader approach to clinical governance across the primary care sector.

...it is integral that indemnity arrangements be designed before new models of care are implemented so that practitioners have cover for the care they provide, and any indemnity questions can be appropriately addressed should they arise. These arrangements should contemplate that multidisciplinary teams may involve multiple employers. Indemnity arrangements would also support clinical governance arrangements. (Consultation participant, insurer perspective)

5.1.4 First Nations voices

Stakeholders representing the First Nations health sector were generally supportive of the intent of the review in seeking to strengthen multidisciplinary team-based care, and reiterated the message that this reflected the way primary health care is delivered effectively in ACCHO settings.

However, consensus was not reached as to whether the combined reform options would be likely to have the intended effect of driving multidisciplinary team-based care in the way it is currently delivered in an ACCHO setting. Governance used in ACCHOs were described as integral to this model and would not necessarily be reflected in the implementation of these reforms. This linked to a broader concern about perceived assumptions that it may be appropriate to 'scale' the ACCHO model across settings and services.

Participants further reiterated that cultural and leadership change was a necessity for the combined reform options, in particular the Matrix and blended funding mechanism, to avoid reinforcing the status quo. There were calls for addressing racism within the sector and workforce and challenging a GP-centric model of care.

There were concerns cultural safety would be omitted or reflected inappropriately as a focus from the Matrix and/or workforce education and training initiatives. There was some disagreement whether it was appropriate to designate cultural safety a 'capability' and concerns the Matrix may unintentionally relegate cultural safety to Aboriginal Health Professionals only. There was broad agreement that consultation with First Nations professionals and communities would be an essential component of the development of the Matrix to ensure that it appropriately reflects culturally sensitive practice.

Participants reiterated calls from others that education and training focused on cultural safety needs to be funded on an ongoing basis. First Nations-specific implementation considerations, that enable the availability of appropriately skilled and experienced health professions to provide locum services in an ACCHO setting, were raised.

A perceived risk was observed of funding and payment policy being used perversely by services in pursuit of profit. Careful consideration of risk adjustment, including stratification by remoteness and Indigenous population as well as age and sex, was advised.

5.1.5 Consumer voices

Consumers were primarily concerned with issues which have a material impact on their experience accessing primary health care, including consumer choice, affordability and accessibility of health services that meet their needs. Some issues of particular focus (especially low bulk billing rates) are outside the scope of this review.

Some reform options, such as a potential consumer-facing Matrix and the independent body to assess workforce evidence, were seen to have potential benefits for consumer transparency and choice. For others, such as risk-based regulation, the implementation approach was seen to be critical in ensuring an appropriate level of transparency for consumers.

Direct referrals were strongly supported, as was a common payment rate for like services, in the interests of equity and consumer access benefits. Consumers remarked that the rationale for the status quo environment was not clear.

Potential perverse incentives of other, more complex funding and payment policy reforms were of concern, and consumers were also concerned about increasing complexity of how primary health care is funded.

Consumers urged that people with lived and living experience should have a critical role in informing the development of all reform options, including in ongoing education and mentoring and development of legislative and regulatory mechanisms. Participants urged that deep consumer engagement should be a core element of the design phase.

5.2 Workforce design, development and planning

Stakeholders who responded to the online survey were asked the following question:

To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?

The collective workforce reforms were acknowledged by many stakeholders during in-person consultation as addressing key policy issues. Many identified the proposed reforms as contributing to a different approach to primary care that strengthened and enabled the whole workforce to provide the patient-centred team-based care needed to manage chronic and complex care in the primary care sector,

Stakeholders commonly cautioned the Review not to consider primary care in isolation when developing reforms. Rather, to recognise the continuum of care and the importance of collaboration across health sectors, which was viewed by many as vital to achieving successful change.

To promote workforce mobility and enable the provision of seamless and integrated care, stakeholders indicated that health professionals should develop, and be encouraged to retain, skills useful across health sectors, and that collaboration across care sectors should be incentivised. Stakeholders also suggested it is important to recognise that health professionals frequently work across hospital and private practice settings, and that this should be supported in the interests of improved care co-ordination.

An additional view expressed by several stakeholders was that health workforce reforms should enable the provision of safe, person-centred care and not be viewed as an opportunity to shuffle health professionals in the interests of convenience or profit maximisation via the employment of the least qualified individual to perform a given role. Rather, reforms *‘must be about strengthening all HCP [Health Care Provider] capabilities tailored to the needs of communities, and the diversity within them.’* (Combined submission, nursing peak organisations).

Consultation identified issues that affect workforce development across multiple disciplines alongside some that occur inconsistently. Many disciplines face challenges in providing primary care training opportunities, interprofessional education experiences and supervision and mentoring to support the workforce. However, differences were identified between disciplines in the funding and payment mechanisms that support primary care workforce development and maintenance. Stakeholders described the significant impact these funding and payment differences have on the ability to develop the primary care workforce and a clear desire to work toward greater cross professional equity in these areas.

5.2.1 Skills and Capability Framework and Matrix

Overall level of support

The concept of the National Skills and Capability Framework and Matrix (the Matrix) was introduced in response to significant feedback received during early rounds of consultation, that indicated poor cross-professional understanding of skills and capabilities. This was viewed as negatively impacting multidisciplinary team function. Stakeholders provided a substantial amount of feedback in response to the proposed Matrix. The following provides a summary of the range of views received in response to the proposed reform.

Stakeholders were asked to respond to the following questions regarding the proposed National Skills and Capability Framework and Matrix:

How should the National Skills and Capability Framework and Matrix be implemented to ensure it is well-utilised?

Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?

Stakeholders indicated general support for this reform, noting the Matrix had the potential to contribute to an improved cross professional understanding of skills, capabilities and roles and to cultivate greater trust between health professionals and with consumers. The Matrix was viewed as providing a foundation for skills-based primary care.

Consumers expressed the view that greater clarity is needed regarding the qualifications of their treating health professionals and that the Matrix could enable this with a positive impact on decision-making.

Development of the Matrix was noted to comprise a significant piece of work. Stakeholders suggested the benefits of undertaking development of the Matrix should be weighed against the considerable time and effort that development and implementation would require. Many stakeholders suggested the Matrix should be implemented as a component of a broader suite of reforms that collectively contribute to genuine change.

A commonly expressed view suggested that a more nationally consistent approach to recognising health professional qualifications, skills and capabilities would positively impact the health workforce and enable the provision of consistent care across jurisdictions. For example, it was suggested that consumers should have access to similar care from nationally regulated professions regardless of where they access that care. Current state and territory-based restrictions, often based on funding and service delivery differences, were identified as preventing this outcome.

Implementation insights

Development of the Framework and Matrix

The following suggestions for developing the Framework and Matrix were received during consultation:

- **The Matrix should be developed with a clear aim.** Stakeholders stressed the importance of ensuring a broad understanding of the intended use of the Matrix. The Framework was identified as an essential contributor to this understanding. Several stakeholders indicated that supporting interprofessional collaboration and the maintenance of multidisciplinary team-based care were important goals for the Matrix. Many embraced the concept of the Matrix, viewing it as a welcome facilitator of cross professional trust through the provision of clarity and visibility of health professional skills and capabilities.
- **A transparent, inclusive approach should be applied to the development of the Matrix.** Many stakeholders indicated the importance of a co-design approach to the Matrix development, inclusive of First Nations representatives, consumers and representatives from all health professions, the paraprofessional workforce, educators, accreditors, professional organisations, service providers, employers, insurers and funders to ensure the product is free of bias. It was widely acknowledged that the development process had the potential to raise conflict and that this should be addressed early. A review of similar frameworks and matrices should be conducted to inform the development process.
- **The Matrix should describe the skills and capabilities of the entire primary care workforce.** Stakeholders were clear that the skills and capabilities of all professions working in primary care be reflected in the Matrix, including regulated, self-regulated, unregulated and paraprofessional workforces. Similarly, it was highlighted that the full range of primary care services, including mental health, disability, aged care services, childhood care services, should be reflected to ensure broad applicability of the Matrix. Failure to do so was considered likely to contribute to fragmentation of the health workforce across settings.
- **The Matrix should identify common capabilities while respecting profession-specific expertise.** Stakeholders agreed that a fundamental objective of the Matrix should be to recognise capabilities that are common across professions. However, several stakeholders indicated the importance of simultaneously recognising and respecting professions for their individual expertise. For example, it was suggested that while cultural safety skills should be identified in the Matrix, the specific skills and capabilities that First Nations health professions bring to care should be specifically recognised.
- **Skills and capabilities should be contextualised.** Stakeholders suggested that where skills and capabilities are common to multiple professions, it may be useful to acknowledge the context in which the profession uses the skill/capability. For example, where skills are used in the context of rural and remote practice or a specific clinical area, there may be specific clinical considerations beyond those expected in alternate settings. These may be relevant to acknowledge in health workforce planning. Similarly, it may be useful to indicate how general capability statements, such as those developed for regulated professions, apply to the primary care setting. There was also a suggestion to

acknowledge the Australian Qualifications Framework (AQF) level of the education program achieved by the health profession. This was considered important to provide an indication of the depth of critical thinking and clinical decision making behind the skill.

- **The Matrix should focus on collaborative competencies.** Commonly, stakeholders viewed the skills required to work as a collaborative multidisciplinary team as important to reflect in the Matrix. These could include communication, teamwork, conflict resolution and leadership.
- **The Framework forms an essential component of the Matrix.** Many viewed the Framework as providing a vital contribution to primary care through the development of a shared language and clear, common definitions. Many stakeholders acknowledged that professions attach different meanings to commonly used language and that establishing a common lexicon would be an important outcome of the Framework. A range of beneficiaries to successful development of the Framework were proposed including education providers, accrediting authorities, professional organisations, employers and consumers. Several stakeholders highlighted the significant positive potential of undertaking the development of the Framework and saw this work as a great opportunity to demonstrate interprofessional collaboration.
- **Existing resources should be utilised where relevant.** Core skills have been defined for advanced practice (e.g. the SA Allied Health Advanced Practice Framework³) and across a range of specialty skill areas such as aged care, NDIS care, diabetes care and prescribing. Where possible, these descriptions should be utilised to support development of the Matrix.

Use of the Matrix

Stakeholders indicated that the Matrix could be useful to many, including health professionals, education providers, accreditation authorities, employers, service providers, workforce planners and consumers. A greater understanding of skills and capabilities resulting from the Matrix was considered an important contribution to the function of the multidisciplinary team, through the generation of improved trust and greater understanding of a professions' capabilities.

Additional views regarding the use of the Matrix and its quality assurance included:

- **Contribution to workforce planning and data sources.** Several stakeholders indicated that to effectively contribute to workforce planning, the Matrix should establish links with other agencies that gather and collate health workforce data, including Jobs and Skills Australia and Rural Workforce Agencies in each state and territory. It was also highlighted that the entire workforce should be reflected in the Matrix to ensure its optimal contribution to workforce planning, although it was noted that this would be challenging for professions that work across diverse settings that may not be included in routine workforce statistics. An example provided was for the paramedic profession who work across a range of settings that are generally not captured in readily available data e.g. defence forces, aeromedical retrieval services.

³ SA Health. [Allied Health Advanced Clinical Practice Statewide Framework](#). Accessed 09 Aug 2024.

There was a view that the Matrix should contribute to *workforce planning* alongside *health service planning*, to ensure required services are available and provided by appropriately skilled health professionals. Several stakeholders indicated the Matrix could contribute to workforce efficiency by enabling a broader range of health professionals to contribute to care and service delivery.

- **Address jurisdictional differences.** The Matrix was viewed by many stakeholders as having the potential to highlight jurisdictional differences in scope of practice and enable the removal of inconsistencies. Addressing jurisdictional differences and enabling national recognition of skills and capabilities was viewed as essential to improving workforce mobility. This outcome was further supported by linking the Matrix with the national digital skills passport.
- **Identify emerging roles and workforce needs, inform education and training programs.** Several stakeholders identified that the Matrix would be instrumental in identifying the skills and capabilities required to address emerging health service needs. In this way, the Matrix could inform education and training programs to ensure the workforce is equipped to meet future needs. Similarly, education providers, National Boards and professional organisations could inform the Matrix where skills and capabilities are updated to reflect changes in practice. Education providers could use the Matrix to inform learning outcomes and assessments. Accreditation authorities could ensure standards reflect the Matrix.
- **Inform development of collaborative clinical pathways** based on each profession being recognised for, and enabled to work to, their full scope of practice. Clinical pathways could be informed by the Matrix.
- **Support individual health professionals.** Stakeholders viewed the Matrix as providing pathways for skill enhancement and the identification of areas for improvement. Incorporation of a self-assessment tool and identification of skills and capabilities across the career progression, rather than just at the entry to profession level, could contribute to this outcome. Consistent with this, it was identified that employers could link role opportunities with the Matrix, which could also inform performance reviews.

Features of the Matrix, quality assurance

Stakeholders indicated that the Matrix would need to be accurate, nimble and user friendly.

A range of views were expressed to describe the **features** of the Matrix considered essential to its usefulness. These included:

- Availability in a range of formats, including in a language and format acceptable for consumers
- User friendly, with clear and intuitive navigation and effective search functions
- Concise
- Dynamic, living
- Indicative of a range of abilities within each skill/capability e.g. within scope, not within scope, within scope but restricted
- Readily understood
- Informative rather than prescriptive

- Accessible
- Digitally enabled.

There was a common view that **quality assurance mechanisms** were critical to success. A range of initiatives were described as contributing to this, including:

- Utilisation of verifiable descriptions of skills and capabilities
- Implementation of an efficient program of regular updates involving a broad range of contributors to ensure the Matrix remains consistent with practice expectations
- Establishment of regular feedback processes to inform further development. Feedback should be gathered from a broad range of users, including consumers. Where practical, the impact of the Matrix on consumer outcomes should be explored e.g. whether the Matrix has contributed to improved access to care.

To contribute to successful development and implementation, stakeholders identified a need for effective pilot testing prior to release, use of digital technology to support design and functionality and a program of widespread education (including interactive demonstrations and training sessions).

Key additional considerations

- **Matrix leadership.** Stakeholders were asked their views on who they considered would provide the necessary leadership to ensure the Matrix achieves the goal of contributing to health professional scope of practice in primary care. In response, a range of views were expressed in relation to both leadership and governance. While some indicated the development and implementation of the Matrix would require the leadership or governance of a single entity (most commonly government), most suggested that leadership across a range of contributors would be necessary and should include professional organisations, regulatory bodies, education providers, health professionals, all levels of government, researchers, collaborative networks, consumers, First Nations representatives, clinical leadership and advisory committees. An alternate view was expressed which suggested the Matrix should be developed and led by an independent team with no bias but state and national collaboration. This view was expressed as an approach that could remove professional boundaries and enable greater collaboration.
- **Enable rather than restrict practice.** Several stakeholders expressed caution to ensure the Matrix did not introduce unnecessary regulatory burden or prevent innovation and responsiveness within the workforce.
- **Skill and capability differentiation.** There was a suggestion that the Matrix could differentiate between skills and capabilities that are commonly acquired and those that are only acquired after specialisation.
- **Expansion beyond primary care.** Noting that many of the skills and capabilities applicable to primary care are common to other health settings, there was a view held by many that expanding the Matrix to reflect broader capabilities could be beneficial to health workforce planning.
- Support was expressed for the development of a **single national framework** for authorised capabilities such as vaccination and prescribing.

- Support was also expressed by several stakeholders for the Matrix to be **linked with funding and policy decisions** to ensure its implementation and use.
- Some stakeholders questioned whether the Matrix would reflect skills and capabilities at the **profession or individual level**, noting that the ability to capture, and search for, the skills and capabilities at an individual level would be useful to inform referrals between health professionals. Others suggested that indicating the skills and capabilities of a profession in addition to that at an individual level would be more beneficial.
- Stakeholders supported the view that efforts should be made to enable health professions who have not yet established skills and capability descriptions to achieve this.

Opposition to the Matrix

While most stakeholders expressed support for the concept of the Matrix, some conveyed opposition. Negative views focused on five main areas.

- Inability to reflect the dynamic nature of practice scope. Some stakeholders questioned the usefulness of a Matrix that was unable to accurately reflect the dynamic nature of practice scope beyond the entry to practice level. This comment was linked to a view that the Matrix would unintentionally ‘pigeon-hole’ professions at the professional entry level. While many stakeholders acknowledged the challenges inherent in describing the skills and capabilities of a profession, it was frequently suggested that this was not a reason to forgo development of the Matrix and its potential contribution to the health workforce. It was suggested that the Matrix be viewed as a ‘floor’ rather than a ‘ceiling’ and in this way be recognised as providing a basic overview of a profession’s skills and capabilities to inform the multidisciplinary team.
- **Viewed as reductionist.** Similarly, some stakeholders considered it impossible to capture the variation in skills and capabilities that exist within a profession. An example provided was that the psychology profession has nine separate specialties which would be difficult to represent. The Matrix was viewed as oversimplifying the skills and capabilities of a profession. Medical practitioners highlighted that the Matrix would fail to adequately represent the complexity of tasks performed by some members of the multidisciplinary primary care team.
- **Potential to confuse the public.** In contrast to most views which suggested the Matrix could be useful to empower consumers and enable informed decision-making, some considered the possibility that the Matrix would create confusion.
- **Unlikely to keep pace with innovation.** A minority of stakeholders indicated that it would be challenging to ensure the Matrix reflected changes in practice and that this could result in an inaccurate publication that retains limited usefulness. For some, this was viewed as a reason not to develop the Matrix. Of note, this comment is consistent with the views expressed earlier that highlighted the importance of effective and ongoing quality assurance mechanisms to ensure accuracy, validity and usefulness.
- **Potential to further entrench professional boundaries** resulting from a profession-specific focus on skill and capability descriptions.

One stakeholder suggested it could be more beneficial to identify variation in skill and capability across the full scope of practice of a profession. This would enable identification of factors that contribute to variations and the impacts of policy decisions on practice scope.

5.3 Develop primary health care capability

This area of reform received a high level of support from stakeholders. Many expressed the view that the reforms had the potential to implement a considerable shift in primary care toward a renewed focus on care outcomes, rather than which professional is providing care. Consequently, the reforms were seen as positively impacting health professionals, consumers and the cultural view of primary care.

Consumers suggested that health professionals need to engage with consumers across their career and that this should begin early during their education and training. It was considered important that consumer engagement is tailored to local contexts and designed to support skill development. First Nations consumers highlighted the importance of health promotion and prevention and the concept that wellbeing reflects more than oneself. These concepts were viewed as important to include in early education and training for all health professionals.

Consultation suggested that reforms should take a comprehensive and inclusive view of primary care, within the context of the broader health system and should acknowledge the high standard of skills and capabilities that currently exist in the primary care workforce.

Challenges experienced by individual professions were noted to differ. Consequently, aspects of reform may require tailoring to address profession- or setting-specific needs. Stakeholders were of the view that no profession should be disadvantaged by the reforms.

Many stakeholders suggested that reforms impacting the primary care workforce should focus on supporting the development of generalist skills and capabilities to benefit the primary care team.

Medical professionals expressed concern that the proposed reforms could have unintended consequences and advised careful consideration to avoid this. There was a view that the reforms could devalue the role of the general practitioner; by failing to fully appreciate the depth of skill and capability this profession contributes to primary care. This group suggested that strengthened communication and systems that support collaboration are essential. Opposition from medical professions was identified by other stakeholders as obstructive to genuine reform.

Stakeholders frequently acknowledged that rural and remote communities have demonstrated innovation in the delivery of primary care and this experience could inform possible reforms. For a range of reasons, rural health care has been required to reconsider how healthcare is delivered in this context. Consequent reforms in rural areas have focused on supporting care led by the most appropriate team member e.g. GP, nurse, midwife and allied health professional-lead care. Consultation highlighted that enabling health professionals to work to their full (or expanded, as often required in rural areas) scope of practice has the potential to provide a range of adjacent benefits, including positive economic and psychological impacts on communities.

Consultation highlighted the common view that initiatives designed to support the multidisciplinary team should be adopted wherever possible. Stakeholders acknowledged the importance of health professionals working together as a contributor to team function, and suggested it is important to support this, including through the development of infrastructure that enables co-location. It was, however, noted that co-location alone does not guarantee functional multidisciplinary teams without additional structural support mechanisms and broad cultural adoption of a team-based philosophy. It was noted that although innovative models of multidisciplinary care have been piloted across the country, widespread adoption of proven models is challenged by range of factors, including specific and differing jurisdictional requirements.

Many highlighted that reforms rely on an adequate health workforce and acknowledged that, for many professions, workforce shortages must be addressed first. Implementing reforms without ensuring the availability of an adequately skilled primary care workforce was identified to be unlikely to be successful.

Stakeholders suggested that reforms should link with existing strategies to support implementation. For example, the National Strategic Framework for Rural and Remote Health⁴ which includes goals that align with this Review and the National Wellbeing Framework.⁵

Many stakeholders expressed the view that reforms should incentivise required outcomes, rather than inputs, to achieve the intended outcomes.

The intersection between this area of reform and legislative, regulatory and funding and payment policy reforms was frequently highlighted. Many stakeholders indicated that effective development of the primary care workforce requires more than addressing issues identified in the education system. Significant change across all three Review themes was highlighted as essential for successful reform, with many stakeholders identifying implementation of reforms as a 'package' as vital.

5.3.1 Support visibility of primary care in entry-level curriculum

Overall level of support

This area of reform received a high level of support from most stakeholders. Consultation identified a common view that early exposure to primary care in education programs is important to enable the development of both a foundational understanding of the sector and the skills and capabilities necessary to work in primary care. Further, quality primary care learning experiences were viewed as important to build the cultural change needed in some professions where acute care roles are more highly valued than those in primary care.

Stakeholders also highlighted, however, that variation exists between professions in the inclusion of primary care learning opportunities in education and training programs, and in the cultural view of the sector. As a result, the reforms will apply inconsistently across professions.

⁴ Australian Government. Department of Health and Aged Care. [National Strategic Framework for Rural and Remote Health](#). Accessed 09 Aug 2024.

⁵ Australian Government. The Treasury. [Measuring What Matters](#). Accessed 09 August 2024.

The establishment of supported training pathways into primary care for all health professions, like those that exist for the hospital sector, was identified as urgently needed to support the development of a skilled and stable primary care workforce.

Implementation insights

- Consultation highlighted the importance of including primary care specific learning opportunities in education programs. Enabling students to develop skills in patient-centred, collaborative primary care practice and an understanding of the sector, including its diversity and place within the wider health system, was viewed as foundational to the primary care workforce.
- There was an acknowledgement that some professions have a predominately primary care-based workforce yet, for many reasons, training remains largely provided in acute care settings. Stakeholders considered the provision of quality primary care training opportunities necessary to the development of skilled health professional graduates, regardless of where they subsequently work.
- The inclusion of First Nations primary health care as an integral component of primary care capability was identified as essential. An understanding of cultural safety, clinical issues affecting First Nations communities, models of care relevant to First Nations communities, the role of Aboriginal Health Practitioners and other care workers in this sector and an understanding of the philosophy of community-controlled care were viewed as critical components of workforce capability.
- For some professions, there is a requirement to complete training in the acute care sector which stakeholders indicated can result in graduates remaining in that sector, rather than moving into primary care. Consultation highlighted the need to broaden the contexts in which primary care training can be completed to support the capacity of the sector to provide learning opportunities. This is particularly relevant to professions with a large student cohort, such as nursing.
- Providing support for, and/or incentivising, collaborative partnerships between education providers and primary care health professionals was considered vital to achieve improved visibility of primary care in pre-professional entry education and training programs.

Key additional considerations

- Stakeholders supported a more integrated approach to the development of primary care capability, inclusive of the skills needed to facilitate care co-ordination across sectors and across professions. This was viewed as a more contemporary model of developing primary care capabilities rather than the traditional siloed approach.
- Consumer involvement in the design, development, provision and assessment of primary care learning opportunities was supported by many stakeholders and viewed as essential to effective learning both within and across professions.
- Integrating primary care into the curriculum was identified as requiring more than simply including additional teaching and learning content. A reprioritising of care toward primary care was considered instrumental to support the reforms and viewed as necessary across a range of areas, including in the community and across strategic and policy decisions.

5.3.2 Support Supervised Practical Training (SPT)

Overall level of support

The provision of quality SPT (or 'placement') opportunities was viewed almost universally by stakeholders as critical to developing a culture that values primary care, and to the development of a skilled primary care workforce. A lack of available placement opportunities in primary care was noted across professions, including in those where substantial growth in the primary care sector has been identified (e.g. psychology). This was acknowledged to be experienced more acutely in rural and remote areas.

Differences were observed between professions in access to resources that support the provision of quality primary care placement experiences. Stakeholders considered this inequity an important issue to address in support of the provision of quality SPT and development of the primary care workforce more broadly.

Consultation highlighted a range of factors that can limit placement experiences in primary care, including:

- A lack of compensation for the reduced income experienced by health professionals who provide training.
- Limited access to appropriately trained supervisors to support quality primary care training.
- Legislation that prevents health professionals from attracting an MBS payment where a student has participated in the consultation.
- The inability to utilise interprofessional supervision, which could enhance training in areas of foundational capability, and contribute to an improved understanding of the role of other primary care team members.

Implementation insights

Supporting the provision of quality SPT was considered integral to developing the primary care workforce and a fundamental aim of reforms. Stakeholders described quality learning experiences as those that:

- Are completed in quality sites where students are valued, encouraged, provided clear expectations and given opportunities to learn and develop their skills and knowledge supported by tailored and effective feedback.
- Are structured, well planned and relevant to practice.
- Provide quality supervision and mentorship that facilitates learning (further described in 5.4.2).
- Do not place the student under financial or other stress.
- Provide opportunities to learn with, from and about other health professions in a supported, non-threatening environment.
- Are free from racism, bullying and interprofessional conflict.
- The specific skills and capabilities required for primary care are defined and reflected in learning outcomes and assessments.

Additional considerations for the provision of SPT include the need to:

- Address the current lack of agreed and co-ordinated models for supervision and mentorship (further described in 5.4.2) to enable the development of a workforce of skilled, supported and available primary care training supervisors.
- Address barriers that prevent health professionals working in primary care from accessing MBS payments for consultations in which a student participates.
- Provide financial incentives for health professionals working in primary care to provide placement experiences and to compensate for the reduced income that accompanies providing training and supervision.
- Expand to all health professions access to student support to participate in SPT.
- Remove barriers to cross professional supervision to enable more flexible and innovative supervision models while recognising the importance of profession-specific supervision.
- Encourage and incentivise, rather than require, a component of program SPT be provided in a primary care setting.
- Support cross professional training opportunities e.g. social work student completing placement in a general practice. This was viewed as contributing to improved interprofessional relationships and a greater understanding of other profession's contributions to primary care.

Key additional considerations

It was acknowledged that for some professions increasing the available places for SPT may be challenging, particularly where there are few primary care professionals. Similarly, increasing the supervision workforce may be challenging for professions with smaller numbers of primary care health professionals. Reforms would need to consider this and other specific requirements of individual professions.

5.3.3 Strengthen Interprofessional Education (IPE)

Overall level of support

This area of reform received a high level of support across all stakeholder groups, who viewed collaborative skills as a foundational expectation for all health professionals across all healthcare settings. While education providers discussed IPE specifically, many stakeholders provided their views on the development of a collaborative health workforce more generally, which was acknowledged as requiring more than IPE alone.

Collaborative skills were described collectively to include an understanding of the role of other professions, recognition of the importance of working together to provide quality care and development of specific skills required to effectively collaborate with other health professions. Most, but not all stakeholders, viewed development of these skills as important inclusions early in education programs; others felt that learning 'on the job' post qualification was adequately effective and less demanding for higher education providers.

Many stakeholders viewed placement experiences as ideal opportunities to develop collaborative skills, particularly when provided in a multiprofessional format. A range of settings were considered appropriate to contribute to the development of collaborative skills, including aged care, disability services, maternal and child care services, mental health care and retrieval services such as the Royal Flying Doctor Service.

Consultation repeatedly indicated that providing quality IPE experiences is difficult, despite the commonly held view that it plays an important role in developing collaborative health professionals. The challenge of including IPE in existing full curricula was commonly raised. Many urged caution to avoid IPE becoming a 'tick box' exercise that fails to provide any real impact on health professional development. Issues raised included scheduling challenges, professional territorialism, disputes over who leads the IPE program, limited resources to provide IPE, poor support from within institutions and challenges in assessing IPE across multiple professions who are bound by differing accreditation requirements. Some education providers expressed a preference for integrating collaboration in the program philosophy, rather than including at a single time point in the program. However, the resources required to achieve this were noted to be commonly lacking and cross professional resourcing raised as a potential solution.

Examples of successful IPE were provided and include:

- Longitudinal placements in which students learn as a team throughout the entire program. This was observed to promote collaboration and to provide a long-term network of professionals on whom graduates could call to provide peer support.
- Provide teaching to support common skills across professions. Examples provided included cultural safety and interprofessional teamwork.
- Immersive exercises that are co-ordinated to bring students together from different disciplines and/or institutions. Prioritising this type of exercise was viewed as indicating the priority of collaboration.

Implementation insights

A strengthened approach to the development of collaborative skills was viewed as requiring:

- Establishment and adoption of nationally applicable general principles to guide collaborative skill development in education programs. This would ensure cross professional consistency in the preparation of graduates equipped to practice collaboratively and alleviate some of the concerns that currently impact the provision of IPE.
- Development of collaborative capability statements to guide both education programs and professional practice expectations.
- The above two options were viewed more favourably than the previously proposed IPE competencies framework, which many considered could pose another regulatory barrier for education providers.
- Establishment of a fund to support partnerships between education and health service providers to support the development of collaborative skills during placement opportunities.
- Implementing a more contemporary approach to the development of collaborative skills, identified as requiring amendments to policy and funding mechanisms which currently to not support an interprofessional approach to training. For example, practice incentive payments support the training of medical students in primary care only when the session is provided by a GP. This therefore fails to recognise and value the learning that medical students could experience that is not GP lead e.g. in nurse led clinics.

Key additional considerations

Stakeholders acknowledged the significant impact that workplace culture has on collaborative practice, suggesting that this makes the workplace either the better training ground for collaborative skills or the environment in which collaborative skills are significantly inhibited. This points to the importance of a broad culture shift to embrace a more collaborative approach to care across all health settings, in parallel with IPE. One factor that may contribute to such a culture shift is multiprofessional learning, further discussed in 5.4.3.

The role of technology in enabling health professionals to work effectively together was acknowledged by many stakeholders who commonly viewed technology as fundamental to achieving successful reform across many areas and particularly as a contributor to collaborative team-based care.

5.4 Early career and ongoing professional development

Stakeholders indicated universal support to provide health professionals who work in primary care with the resources to maintain and enhance their skills. A range of issues were identified as preventing and/or limiting access to post professional entry education and training, including that required to support mandatory continuing professional development, where applicable. Issues include limited access to appropriate education, mentorship and collaborative learning opportunities. To address these issues, stakeholders identified a need to shift culture and amendment to policy settings towards a more equitable application of resources across professions in support of health professional skill development and maintenance.

5.4.1 Support for post-professional entry education and training

Overall level of support

Stakeholders supported improved consistency in the recognition of post professional entry education and training and identified that limited recognition currently impedes health workforce mobility and, in some areas, contributes to local requirements for unnecessary re-certification. Implementation of the National Skills and Capability Framework and Matrix was identified as providing national recognition of qualifications, although it was noted that the Matrix would initially focus on skills and capabilities at the professional entry level, rather than recognising post-professional entry qualifications and competency in advanced areas of practice.

Access to ongoing education and training to support and enhance scope of practice was considered critical to the maintenance of a highly skilled and stable workforce and identified as particularly challenging for professionals who work in sole practices who, for many professions, are unsupported to complete education and training and commonly experience financial penalties when doing so.

Equitable access to resources, including financial, that support completion of post professional entry education and training for primary care health professionals was highlighted as critical to achieving meaningful reform that demonstrates the primary care workforce is valued and respected.

Appropriate recognition of post professional entry qualifications, including via remuneration, was considered an important motivator for health professionals to maintain and advance their skills.

Implementation insights

- Access to affordable, modular education and training that contributes to primary care capabilities was viewed as critical to support the primary care workforce.
- Development of, and access to, programs that support health professionals during the transition into primary care was consistently viewed as valuable to early career professionals, those from all stages of the career who have not previously worked in primary care and those who completed their initial education and training outside of Australia.
- For First Nations health professionals, early career support provided on country and/or through mentoring in the workplace was viewed as necessary.
- Stakeholders consistently identified that appropriate recognition and remuneration for post professional entry qualifications is essential to maintaining the workforce and providing motivation to continually improve skills and capabilities.

Key additional considerations

Stakeholders considered it important for education programs to align with recognised professional standards and/or competencies, including across professions where common capabilities are identified.

5.4.2 Supervision and mentoring

Overall level of support

Stakeholders expressed a high level of support for improvements to the supervision of health professional students in primary care (as described above in 5.3.2) and for the establishment of greater consistency and availability of mentorship and peer support and/or coaching across the career continuum. Many viewed these improvements as critical to prevent professional 'burn out' and to maintain a stable primary care workforce.

Quality supervision and mentorship were identified as critical to training, yet severely undervalued. Currently, for many professions, supervision is provided without remuneration and in addition to the regular clinical and business workload, resulting in supervisors feeling undervalued and the potential for students to experience poor quality supervision. Stakeholders expressed the need to build a quality supervisor workforce across all professions and sectors, including the Vocational Education and Training sector.

Supervision

Stakeholders described profession-specific mechanisms developed to prepare health professionals for a supervisory role, either as a mandated requirement for supervision or accessible as required by the individual supervisor. Many suggested that rather than approaching supervisor preparation according to a profession-based model, there is a need to establish a co-ordinated model for supervision and a national framework to support development of a skilled supervisory workforce.

Interprofessional supervision was raised as a potential contributor to primary care training and highlighted as useful to the development of foundational skills common to multiple professions. Remote supervision was suggested as potentially enabling training opportunities, particularly when supported by face-to-face supervision provided by another health profession. To support these models, and enable cross professional trust in supervision, shared supervisory training pathways and practice expectations were suggested.

However, several stakeholders cautioned that interprofessional supervision would not be suitable for profession-specific practice areas which would require profession-specific expertise in supervision. Similarly, interprofessional contribution to student assessment may be relevant for some skills but should not replace profession specific assessors in areas of profession-based expertise.

The supervisor role was identified as particularly critical to support primary care training experiences in rural and remote areas. It was noted that in this context, supervisors commonly provide pastoral care as part of the supervisory role, especially where students have relocated to rural areas to complete training.

Mentorship, peer support and coaching

Quality mentoring and peer support programs were viewed as important contributors to health professional confidence, capability and ultimately retention in the primary care workforce. Currently, mentorship is commonly directed at the health service provider level, leaving health professionals who practise as sole traders isolated, unless able to link with mentors, including those from other professions, either locally or remotely.

Stakeholders identified that contemporary mentorship models see health professionals engaging multiple mentors who contribute to their practice in different ways or in relation to different aspects of practice. Effective mentorship was noted to require structure and clear expectations, particularly when provided across professions, or as part of a team of mentors. It was also acknowledged that informal episodes of mentorship and/or peer support, including 'teaching on the run' style mechanisms are valuable yet highly undervalued.

Communities of practice were highlighted as important to support health professionals through the provision of advice, mentorship and general peer support.

Consultation highlighted that appropriate remuneration is fundamental to quality supervision and mentorship. While many professions have a culture that expects health professionals to support junior team members as part of their professional practice, stakeholders acknowledged that most health professionals are working to capacity and the additional responsibility of providing supervision and/or mentorship without remuneration or capacity is unrealistic and unsustainable.

Access to remuneration for supervision varies between professions, although for most primary care professionals is unavailable. When combined with the previously described legislative barriers that prevent health professionals from accessing MBS payments for consultations that involve students (section 5.3.2), a lack of remuneration for supervision severely restricts establishment of quality training in primary care. Mentorship programs are available for some professions, but inconsistently across professions.

Similar to supervision, stakeholders suggested a need to develop a co-ordinated cross professional model for the preparation and availability of mentors.

Implementation insights

- Stakeholders identified a significant need to value and resource supervisors and mentors in primary care as substantial contributors to the development and support of the primary care workforce.
- A national approach to developing and supporting the supervisor and mentor workforce was suggested, which could include the adoption of a national mentoring capability framework and national supervision framework and the establishment and resourcing of supervision and mentorship pathways consistent with nationally adopted frameworks.
- To encourage development of a sustainable workforce of quality supervisors and mentors, stakeholders highlighted that adequate remuneration is 'key' and currently available inconsistently across professions.
- Stakeholders also suggested that peak professional organisations could be supported to develop and co-ordinate communities of practice to provide advice, mentorship and support for early career health professionals.
- A range of successful examples of mentorship and supervision were provided, including those that function across health sectors. For example, general practitioners with extended scope procedural skills supervised and mentored by specialist surgeons, mentoring and collaboration between general practitioners and paediatricians to provide care for rural and remote children.

Key additional considerations

Stakeholders indicated that for small professions (e.g. orthoptists/prosthetists) limited mentors are available, particularly in rural areas. Developing the mentor workforce could be challenged by low levels of available health professionals to contribute to this outcome.

For some professions, a lack of available supervision and support can result in under-utilisation of the workforce. For example, Aboriginal Health Practitioners, who have a wide scope and work across diverse areas such as community care, liaison, social and emotional wellbeing, family support programs, aged care and disability services, are commonly challenged in the ability to identify suitable supervisors which can impact their ability to contribute to care.

Delegation/supervision models that apply to the allied health assistant (AHA) workforce require specific supervisory skills. Stakeholders indicated that the inclusion of specific delegation skills applicable to AHAs in continuing professional development programs could support this workforce.

5.4.3 Multiprofessional learning (MPL)

Overall level of support

Stakeholders expressed the view that MPL has the potential to contribute to a positive primary care team culture and functional multidisciplinary teams. This area of reform generated significant discussion focused more broadly on mechanisms that support collaboration between professions and health sectors.

Reforms that improve the accessibility of MPL across primary care health professionals were highly supported. It was frequently noted that primary care teams often work outside of general practice and should be supported to access MPL relevant to their contexts.

Consultation identified that MPL is available to support rural and remote practice, including that provided by Rural Clinical Schools (RCS), University Departments of Rural Health (UDRH) and the Australian Rural Health Education Network.

Building interprofessional collaboration at the points of intersection between primary and secondary/tertiary care was widely acknowledged as important to the provision of well co-ordinated health care. Multiprofessional education and training programs that span health sectors were considered important contributors to this aim.

Professional boundaries and insecurities were identified as frequently having a negative impact on the provision of MPL. Stakeholders frequently expressed the view that all health professionals are connected by the common goal of providing effective healthcare, which was viewed as an important foundational focus for all MPL and contributor to the removal of cultural divides between professions.

Implementation insights

- Stakeholders viewed MPL as important to developing the multidisciplinary team, whether provided in a formal or informal capacity.
- Mentorship pathways that engage with MPL were highly supported as a way of supporting both individual health professionals and the broader care team.
- Stakeholders expressed strong opposition to MPL being mandated through continuing professional development programs. The view that MPL should be incentivised was, on the other hand, clearly supported, and achievable through dedicated funding to support the design and delivery of MPL and health professional participation.
- Peak professional organisations and registered training organisations were identified as having a significant role in the development of MPL applicable to a broad range of health professionals. Stakeholders viewed it important to incentivise this outcome.
- Rural health professionals were identified as requiring priority funding to support participation in MPL.
- A common view was that MPL and, more broadly the multidisciplinary team, do not need to be led by GPs and that alternate mechanisms to support the team should be developed and provided.
- The Primary Health Networks (PHNs) were seen as important facilitators of MPL. However, it was noted that many PHNs engage with medical professionals as a priority and infrequently include other health professions. Stakeholders considered that PHNs have a key role in supporting nursing and allied health professionals in primary care and that the development and implementation of MPL should be a priority for these organisations.

Key additional considerations

Building the multidisciplinary team was viewed as contributing to seamless care. The multiple entry and exit points of care should be managed to avoid consumer confusion and facilitate care that, from the consumers perspective, is provided by one cohesive team.

Greater co-ordination of operating and funding systems across care settings was viewed as important to effective collaboration. For example, eye care commonly spans two health sectors, each of which has different systems. This can challenge the provision of cross sector seamless care.

Stakeholders indicated that extending the Work Incentive Payment (WIP) to include a broader range of health professionals to work and learn together could contribute to the development of more effective multidisciplinary teams.

5.5 Legislation and regulation

Participants were asked to respond to two general questions about the legislative and regulatory reform options proposed in Issues Paper 2:

What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

The single most-supported reform outside of the specific proposed reform options was consideration of additional regulation and/or title protection for self-regulated health professions. Most stakeholders who represented self-regulated professions commented on the fact they were by default excluded from the reform options proposed, because they are not regulated under the NRAS. Some specific implementation strategies were suggested, such as the introduction of a single joint allied health board under the NRAS, similar to approaches in the UK and New Zealand. This was generally described as important to progress in addition to, not instead of, the legislative and regulatory reform options.

5.5.1 Risk-based approach to regulating scope of practice to complement protection of title approach

In addition to the general questions about legislative and regulatory reform options, participants were asked to respond to the following specific question about the value and implementation pathways for a proposed risk-based approach to regulating scope of practice to complement protection of title approach:

To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?

Overall level of support

There was overall support voiced for this reform option, contingent on several implementation assumptions. Notably, there was a strong view that the priority of this reform option should shift from high-risk activities, as proposed, to higher-volume, lower-risk activities which better reflected community need and are commonly shared across professional scopes of practice. Support was highly contingent on this reform option being a complement to, rather than replacing, protection of title. Stakeholders reiterated the view that this reform option would be effective only with a balanced approach to implementation.

Implementation insights

- Participants conveyed an overall negative reaction to this reform being named a 'risk-based' approach and focusing on high-risk activities in the first instance. Participants broadly preferred this reform to focus on higher-volume, commonly shared activities in the first instance, which they saw as better addressing community need.
- Mapping of community need was one commonly suggested avenue of identifying an initial subset of activities to fall under this regulatory mechanism.
- Corresponding to the above preference, several alternative ways of referring to this reform were suggested, including 'activity-based', 'skills-based' and 'competency-based' regulation. These were seen as more clearly linking the intent of the regulation as reflecting shared skills, capabilities and activities.
- Some concerns were voiced, particularly by representatives of the medical profession but shared by some non-medical stakeholders, that pursuing activity-based regulation could have the unintended consequence of minimising the value of primary health care to overly specific activities.
- A strong viewpoint among representatives of self-regulating professions was that this reform option would not be effective in the absence of parallel efforts to strengthen the regulatory environment surrounding self-regulated professions. There was moreover some concern expressed about this reform option reinforcing the status quo in relation to self-regulated professions. Stakeholders who expressed this view generally supported increased title protection for self-regulated professions in addition to, or instead of, activity-based regulatory approaches in order to address this perceived exclusion.
- Some concerns were voiced that this mechanism may unintentionally promote health professionals working above their individual scope of practice. The need therefore emerged to clearly convey that risk-based regulation would apply to individual scope of practice only in the context of specific multidisciplinary care teams and their clinical governance arrangements.
- The challenges of capturing the full breadth of individual scope of practice through this reform were observed. Some stakeholders called for an articulation of the level of education needed for authorisation to perform a particular activity, inclusive of additional qualifications or endorsements. Without this, stakeholders saw that an activity-based regulatory approach may limit scope of practice for some health professionals.

Key additional considerations

- Numerous participants saw a natural role for this reform option as a flow-through or output of the Skills and Capability Matrix and Framework (see 5.2). They observed that the Matrix would identify a range of shared skills and capabilities which could inform those selected as priority for activity-based regulation. The Matrix was also seen by some as crucial to mitigate the risk of increased regulation unintentionally limiting scope.
- Some suggested that the independent mechanism charged with assessing innovative health workforce models could have a role in informing or maintaining the list of in-scope activities for this regulation.
- This reform proposal was described by some stakeholders as a challenge to the current medico-central model, in that it would explicitly authorise activities already within the

scope of health professionals to be delivered. Stakeholders were divided along professional lines around whether this was appropriate or inappropriate. Some further remarked this reform proposal would be unlikely to achieve on its intended impact without the addition of other legislative, funding, cultural and leadership changes.

- The need for a program of sector and public education about this reform proposal was highlighted, as this reform was seen as complex due to its relative unfamiliarity.
- Numerous participants raised that rigorous monitoring and evaluation would be necessary to support implementation, enable transparency, and protect consumer safety as health professionals adapted to the new regulatory process.

5.5.2 Independent, evidence-based assessment of innovation and change in health workforce models

Participants were asked to respond to the reform option proposed in Issues Paper 2 of an independent, evidence-based assessment of innovation and change in health workforce models, through the establishment of a new independent mechanism to conduct this assessment on an ongoing basis.

Overall level of support

There was overall a high level of support and enthusiasm for this reform option, which was seen as filling a critical gap in the primary health care system in translating evidence into practice and creating a primary health care system that is overall more responsive to innovation and best practice.

Implementation insights

- There was overall consensus that this mechanism should not be housed within Ahpra, both because it implied a scope limited to regulated professions (excluding self-regulating and unregistered professions), and because its regulatory function was seen as inconsistent with the intent and work of this independent mechanism. However, many stakeholders proposed the body should be housed in an 'Ahpra-like' institution in terms of its overarching role above specific professions. The Australian Institute of Health and Welfare was suggested as one potential institution to house the mechanism.
- It was noted across most consultations that there was an inherent risk of this independent mechanism being used to drive vested interests. People specifically raised that, in the absence of careful selection criteria for advisory representatives, the independent body could reinforce the status quo in terms of where power and funding is situated in the primary health care system. Participants suggested joint nomination of representatives by relevant professional organisations, who would sit in advisory role not as a representative of their profession but of their broader practice area.
- A broad range of stakeholders emphasised that the mechanism should strive to represent a genuinely non-hierarchical and interprofessional structure and culture. Representatives of allied health professions expressed the particular importance of fair allied health representation to inform the mechanism.
- Rural and remote stakeholders urged the independent mechanism to take a rural focus to its ongoing work, highlighting that innovative practice often occurs in rural areas but requires additional resources to bring this evidence to light on a broader scale. An

approach to 'research with' these communities was seen as important to address ongoing concerns about the ability to resource research work in rural and remote areas which face workforce shortages (e.g. embedding researchers in local communities, enabling them to build rapport and trust over time).

- There was broad consensus reached around the need for the independent mechanism to consider a range of evidence types to inform practice and avoid reinforcing existing power dynamics within the primary health care system. Local pilot models of care and qualitative research were called out as important for the independent body to take into consideration, in addition to peer-reviewed research, randomised controlled trials and other widely recognised sources of evidence.

Key additional considerations

- Many participants raised concerns that an independent mechanism focusing on primary health care workforce was overly limited in its scope and may overlook examples of good practice in other areas of practice. It was variously recommended that the independent mechanism consider evidence about adjacent areas of health, such as aged care and disability, or health more broadly, taking in evidence not limited to workforce models. Comparisons were frequently drawn to the former Health Workforce Australia and some specifically raised that the establishment of this mechanism should draw learnings from that now-defunct body.
- The work of the independent mechanism was seen as a critical opportunity to invest in First Nations-led research and build the capacity of First Nations communities in developing evidence about what works in primary health care, and bringing these to broader attention for potential scaling-up.
- The above advice notwithstanding, numerous participants highlighted the need for any advice shared by the independent body to take into account the local context and the impact this may have on attempts to scale pilot programs or other research.
- An opportunity was identified for the independent mechanism to input into the Skills and Capability Matrix and Framework, as a way of ensuring the latter remains current in reflecting primary health care practice and innovation.

5.5.3 Harmonised Drugs and Poisons regulation to support a dynamic health system

Participants were asked to respond to the reform option proposed in Issues Paper 2 of a harmonised Drugs and Poisons regulation to support a dynamic health system, as the first step in a proposed broader harmonisation reform agenda.

Overall level of support

There was overall strong support for this reform option voiced across professional groups. Drugs and Poisons was, with few exceptions, viewed as the natural place to commence the harmonisation agenda due to its significant material impact on scope of practice in primary health care. Overall, there was a view that harmonisation was broadly seen as worthy of pursuing despite inherent challenges, in terms of the significant impact the existing Drugs and Poisons legislation landscape has in limiting scope of practice in primary health care.

Positive implications particularly for rural and remote regions, and border communities, were highlighted.

Implementation insights

- Consistent with previous phases of consultation, participants highlighted the inherent challenges in pursuing harmonisation across a federated model, and the likely difficulty of reaching consensus across all States and Territories.
- In light of the above, many participants supported a staged approach to harmonisation that commenced with relatively lower-complexity consensus-building activities that would nonetheless have a potentially significant impact on scope of practice – particularly developing a consistent glossary of shared definitions. Moreover, it was generally seen as a reform agenda which could be progressed relatively independently of other reform options proposed in Issues Paper 2, which could achieve its intended effect without significant dependencies.
- Full harmonisation was generally supported as an end point, although some stakeholders suggested the possibility of partial harmonisation as an end goal (such as harmonisation in relation to one profession, or agreement on a shared glossary).
- Definitional inconsistencies, such as varying use of 'health practitioner' across jurisdictions, were highlighted as needing resolution through harmonisation efforts, through a shared glossary or similar (as above).
- Stakeholders emphasised the importance of learning from past precedent in attempting harmonisation. Partial harmonisation of Work Health and Safety legislation was raised as one precedent.
- Representatives of the medical profession raised that this could be an opportunity for greater consistency in areas of limited scope of practice for the GP profession, such as prescribing ADHD and some acne medications.

Key additional considerations

- Most participants were supportive of the broader reform agenda of harmonisation, which was seen as improving consistency of practice with positive implications for scope of practice. Participants raised a number of examples of potential 'next steps' for harmonisation, particularly radiation safety.
- Some stakeholders proposed review of the PBS to ensure restrictions were removed to further support harmonisation implementation, such as the PBS requirement for a condition to be 'ongoing' in order for nurse practitioners to prescribe/initiate some treatments.

5.6 Funding and payment policy

Stakeholders were supportive of funding and payment policy reforms outside the scope of this review, such as increased quantum of funding for primary health care and increased direct funding of allied health professions and pharmacists. Some stakeholders supported a more radical change to primary health care system funding which allowed funding to follow the consumer, similar to the mechanisms in place in NDIS and aged care systems.

5.6.1 Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice

Participants were asked to respond to the following questions about the value and implementation pathways of funding and payment policy reform, including funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice.

To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

What other implementation options should be considered to progress the policy intent of these options for reform?

As drafted in Issues Paper 2, this reform option was assumed to be inclusive of the below sub-options:

- A. Broad based, risk adjusted blended payment for primary health care
- B. Single payment rate for like services within common scope
- C. Bundled payment for midwifery continuity of care models

5.6.2 Broad based, risk adjusted blended payment for primary health care

The blended payment was presented to participants as a complement to the existing fee-for-service payment, indicatively as a 60:40 split, with an underlying risk stratification mechanism to determine the applicable blended payment based on local community need. The blended payment was proposed to blend and cash out a range of existing payments (such as Workforce and Practice Incentive Payments, Section 19(2) exemptions and a range of others), and would apply to a range of primary health care service types, including general practice, Aboriginal Medical Services, and State and Territory-run primary care services. Further, the blended payment was proposed to be contingent on MyMedicare enrolments. A principle that services would be 'no worse off' in the application of the funding mechanism was also assumed.

Overall level of support

There was overall agreement that there was a need for reduced reliance on fee-for-service payments in the primary health care system, including through increased block payments. Broadly, there was a positive response to the concept of moving towards a blended payment model in primary health care, with varying opinions voiced about the specific appropriate split of block to fee-for-service funding.

There was broad agreement that the introduction of a blended payment would contribute to better funding the aspects of primary health care that are not adequately addressed by fee-for-service payments, such as care for consumers with complex health needs and wraparound care. The payment was also nominally seen to increase services' ability to employ non-medical staff members, particularly in the presence of other reform options and cultural change management. However, some stakeholders noted that the block payment was likely to incentivise larger multidisciplinary team sizes operating under individual practices, which may be associated with the risk of overservicing or fragmented care.

The need for strong monitoring and evaluation mechanisms was viewed as important across the board, as was a robust risk stratification mechanism to ensure health services were funded equitably based on community need.

Implementation insights

- The proposed blended payment was described to participants in the in-person consultations as intending to incentivise the employment or contracting of specific services (with a focus on non-medical members of the multidisciplinary care team) who could meet community need. The majority agreed that the blended payment represented an improved incentive for services to employ non-medical staff compared to the status quo, and could therefore help to establish more robust multidisciplinary care teams at the individual service level.
- The majority of participants who were asked specifically about their views on a potential 60:40 split (fee-for-service to block funding) were in agreement that this broadly reflected the split of episodic to complex care they were required to deliver to meet community need.
- The specific risk stratification process underpinning this reform proposal was described as a key dependency for effectiveness. Stratification by remoteness, socioeconomic status and Indigenous status was advised by First Nations and other participants, which was viewed as more appropriate than age and sex-based stratification alone. The use of existing service-use data for risk stratification purposes was strongly criticised as this data conflates community need with access to services. Rural and remote participants advocated for rural loading to a level which would address the discrepancies stemming from the reduced availability of GPs in these areas.
- The potential for an outcome measurement attached to the blended payment was discussed. A combination of patient-reported experience measures and outcome measures was suggested, with some noting that in the case of people with chronic or complex health needs, outcomes were not necessarily a realistic indication of the quality of care delivered. Stakeholders further raised the risk of “unobtainable outcomes particularly in lower socioeconomic areas” which would reduce the incentive for health professionals to work in these areas.
- Some stakeholders explicitly did not support attaching the blended payment to participation in formal shared care arrangements, which they viewed as likely to exclude broader members of the multidisciplinary care team, particularly allied health.
- There was some concern expressed that by flowing the blended payment to existing services, there was an inherent risk of reinforcing the status quo GP centric model of, given that decision-making in how to allocate the payment would fall at the individual service level. Many from non-medical professions expressed a view that these decisions may be made with a bias towards GPs as the default provider of care (particularly as they attract a higher MBS payment for particular activities) and may exclude allied health, pharmacy, nursing and other professions who could be brought within the service team as salaried staff.
- Relatedly, many participants noted that the blended payment would not, in and of itself, shift assumptions about who would perform the care coordinator role within the multidisciplinary care team. While some participants advocated for a broader view of the

care coordinator role, in the absence of specific mechanisms in place, there were observed to be continuing material barriers to people other than the GP from performing a care coordination role in practice.

- Furthermore, representatives of allied health professions raised concerns about the lack of specific mechanism for flowing funding to members of consumers' multidisciplinary care team who work outside of the specific practice, other than through existing mechanisms such as Chronic Disease Management Plans. This was seen as potentially disenfranchising parts of the multidisciplinary care team.
- The need to pilot blended payments outside of general practice-based settings was suggested on the basis that non-GP centric models had not yet been tested in the Australian context or previous trials such as Health Care Homes and My Medicare.
- Numerous stakeholders did not support the concept of 'cashing out' MBS Chronic Disease, WIP and PIP items, and aged care items on the basis that further detail was required as to the rationale and mechanism for consolidating these payments.

Key additional considerations

- Consumers raised that the principle of consumer choice meant that they should not be disincentivised from continuing to seek the services of a preferred provider, even if they do not work under the roof of their main provider or care coordinator. Participants also questioned how consumers who chose not to enrol in My Medicare could benefit from this reform option.
- Some participants raised a perceived risk of the blended payment being used perversely by health services to maximise profits, i.e. by accepting the payment but failing to deliver the services for which it was intended. However, agreement was somewhat reached that this effect would likely be limited to a small number of bad actors, and that monitoring and evaluation strategies would be important to mitigate this.
- If the funding model was to be piloted, participants provided advice that the pilot program would need to be of sufficient length to generate evidence, and the longer term impact on the community should be considered (including potential impact of lapsing short term pilots).
- The complementary role of a single payment for like services was identified as working alongside the blended payment to incentivise services to employ non-medical health professionals as part of the multidisciplinary care team.

5.6.3 Single payment rate for like services within common scope

Overall level of support

Overall, stakeholders expressed mixed views about this reform option. For those who supported this reform option, it was seen as an important contribution to interprofessional equity, as well as to remove significant disincentives to specific activities being delivered by non-medical professionals. Broadly, consumers also conveyed the view that a single payment rate reflects their assumptions about how their care is paid for, and that the status quo appears inequitable.

However, many representatives of the medical and other professions expressed that this reform option may serve to devalue the additional care offered in primary health care

consultations, which may not be limited to a specific activity and may not fall within the scope of practice of all health professions. Moreover, it was seen as inconsistent as with the differing skills, experience and training of members of the primary care team. Further, they raised that it did not take into account the different professional and business contexts in which the 'like' service was delivered.

Implementation insights

- This reform was viewed by its proponents as a key mechanism to incentivise the use of non-medical health professionals to perform specific activities within their scope, which they described as currently disincentivised. These participants viewed a single payment model as having potential positive flow-on impacts for the entire health care team, as medical staff would not be required to be involved in all episodes of care for the service to claim the higher payment, and could themselves focus on higher scope of practice care.
- Most participants were in agreement that the single payment rate would need to reflect the highest rate applicable to a given service, i.e. the rate received by GPs. However, many GPs disagreed with this concept, and stated that the higher payment rate for GPs was reasonable based on their level of qualification relative to other professions. Many of these participants raised that opportunistic services that could be provided by a GP to accompany a particular activity could not be offered by all other health professionals delivering that activity, such as opportunistic screening or diagnosis.
- Some participants queried whether the assumption of 'like services' was credible, not only because different health professionals may undergo different training and qualifications to perform the same task, but because the task may be described differently across relevant MBS funding rules. There would therefore be a need for careful review of in-scope activities for this reform option.
- Some consumer representatives expressed surprise that there were unequal payment rates currently in place for what they assumed to be identical services, such as vaccination. Some stated that a single payment rate would represent the 'common sense' approach for most consumers, and understood that this would be likely to help improve access to care by removing pressure on their GP to be involved in aspects of care which could be managed by another member of their health care team.

Key additional considerations

- This was an area of clear discord along professional lines in terms of understanding how different health professions deliver activities that fall within a shared scope of practice. This means that any change to funding rules which moves towards equalising non-medical and medical payments would need to be accompanied by significant change management communications around the intent of these changes in terms of delivering more consistent care to the consumer.
- Examples discussed were functional tasks (such as vaccination) performed by multiple health professions. In the case of consumers with complex health needs, some participants raised concern that the single payment rate may imply that a health professional with the activity within their scope could always perform that activity independently, whereas external supervision or advice may actually be required. It is noted, however, that this reform option is assumed to apply in the first instance to

activities which are already shared between multiple professions, who currently manage such instances within their care team's clinical governance arrangements.

5.6.4 Bundled payment for midwifery continuity of care models

Overall level of support

There was overall a broad consensus that a bundled payment across midwifery would have significant value in resolving scope of practice issues which arise across the midwifery journey. While this was most strongly supported by representatives of the midwifery profession, there was overall enthusiasm for the model across participants. Numerous participants raised that other conditions with relatively predictable pathways would be candidates for expansion of the bundled payment model.

Implementation insights

- An important potential perverse incentive was frequently raised where the bundled payment could limit the care provided to people with more complex presentations, if there was not sufficient flexibility in the payment to allow for different levels of complexity. Incorporating a risk-adjustment was suggested by many of those who raised this point.
- The complexity of introducing a single payment across State, Territory, Commonwealth and private services was raised. Participants urged that the bundled payment must avoid adding complexity to an already convoluted payment process. This linked to consumer feedback that paying for primary health care should not increase in cost or complexity.
- Diabetes and some high-volume treatable cancers were suggested as examples for expansion of the bundled payment program, with the potential to address common scope of practice and continuity of care issues consumers encounter when accessing care.

Key additional considerations

- This reform option was specifically highlighted as being potentially beneficial to Birthing on Country models, but that it would need to recognise and flow funding to non-midwifery members of the care team in order to do so.
- Representatives particularly of the midwifery profession raised that the interface with privately practicing midwives should be considered, including home births.
- Some participants pointed to previous work by IHACPA, drawing from examples in the USA, as a basis to learn from.

5.6.5 Direct referral pathways supported by technology

Participants were asked to respond to the following questions about the value and implementation pathways of funding and payment policy, including direct referral pathways supported by technology.

To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

What other implementation options should be considered to progress the policy intent of these options for reform?

The direct referral pathways in scope for this reform option were assumed to be restricted to specific professions and instances clearly within the scope of that profession, such as those related to specific high-volume diagnostic groups. These were assumed to be associated with an automatic digital notification to the home service in which the consumer is enrolled, through an integrated digital environment still under development.

Overall level of support

This reform option was met with significant support from both consumers and non-medical professions. To its proponents, it was seen as a means to both resolve a significant consumer frustration and access issue in navigating the health service, while enabling more non-medical professionals to exercise clinical judgment and thereby work closer to full scope. Representatives of the medical profession held mixed views about the value of this reform option; some supported examples of pathways (such as physiotherapist referring to orthopaedic surgeon) that they saw as having value. Many others were concerned about implications for fragmentation of care, and did not support this reform option. In all cases, the automatic notification back to the home practice was viewed as a core element of this reform option promoting interprofessional communication, care integration and patient safety.

Implementation insights

- Medical concerns about fragmentation of care were related to assumptions that this change in funding rules may enable non-medical professionals to refer a patient to other services without the knowledge of the general practitioner, with potential consequences for quality of care (or patient safety, in the case of complex health needs with the referrer or referee may be unaware of). These concerns were generally alleviated by the assumption that the referrals would need to be accompanied by an instantaneous digital notification to the home practice.
- There was disagreement about how far the direct referral reform should extend; many stakeholders particularly those representing allied health professions supported a broad approach with all (or most) regulated and self-regulated professions able to refer between each other; while others supported a more restricted approach.
- The specific mechanism for the digital notification was not agreed. My Health Record was broadly agreed to lack the current functionality for this purpose, notwithstanding that many primary health care professionals do not have the ability to upload information into My Health Record. Some stakeholders disagreed that a digital mechanism was essential for these additional direct referral pathways, and expressed that non-digital referral methods are currently used effectively in primary health care. Moreover, it was observed that there are barriers to non-GP team members using existing digital health systems (such as additional charges to use software which is free of charge to GPs).
- Some supported this reform option being accompanied by a rule stating the referral must be accompanied by a full patient summary, as was proposed in in-person consultation. This would be contingent on a level of information sharing between all members of the multidisciplinary care team, including across services, in many cases to a greater extent than is currently occurring across the primary health care system.
- A potential trial was raised of using direct referrals as a bypass in urgent situations where a GP is not available or present, where the referral is clearly within the scope of the referring team member.

- There was support among some professions (notably pharmacy and some allied health) that direct referrals to pathology and imaging in specific circumstances would resolve key scope of practice and consumer access issues. This point was broadly not agreed by medical professionals due to a perceived risk of overservicing.

Key additional considerations

- Consumers strongly supported this reform option as addressing a very common issue experienced in accessing primary health care, particularly for people with comorbidities and complex health needs. These participants conveyed a clear message that the purely administrative nature of many GP visits required to get referrals represented a burden both on themselves and on the GPs, in terms of time and cost. This view was echoed by many rural and remote stakeholders who noted that the burden of accessing a GP for a referral in their regions was significant.
- Many participants agreed that this reform option could be used as a means to drive overdue reform to digital health and information sharing systems. However, scepticism was also expressed that this could occur in a timely manner to enable this reform option to take effect.
- There were some concerns that new direct referral pathways may not be accepted by all services receiving referrals, in the absence of change management and communications that explicitly outlined the scope of practice of non-medical referring professions and the intent behind this reform.
- Some views were expressed that a payment should accrue to the referring service for making a referral, which is outside the scope and intent of this reform option. This indicates a potential need for clear communications that the MBS payment for accessing the referred service would flow to the consumer, not the referring health professional

6 Conclusion and next steps

6.1 Summary of findings

The key findings across this stakeholder engagement report are summarised below. Overall, participant feedback provided a reinforcement that the combined reform options are seen to be of value in achieving the intent of the Review, and a wide range of implementation considerations were provided to support effective implementation.

Table 2: Summary of Stakeholder Engagement Report 2 findings

Theme	Key Finding / Reform Option	Description
Cross-cutting theme	Overarching views on direction and scope of Review	<ul style="list-style-type: none"> General support for the overall reform direction, contingent on implementation considerations and effective change management processes.
Cross-cutting theme	Leadership, culture and governance	<ul style="list-style-type: none"> Governments, professional organisations, education providers, consumers, regulatory organisations and health services all emphasised as key players, and working together as a priority. Recognition of community need as a driver of reform. Collaboration between all members of the care team through a non-hierarchical approach and commitment to a clear reform vision. Cultural change required to transform primary health care, challenging entrenched power dynamics. Evaluation and monitoring of the outcomes of reform viewed as important to ensure the goals of reform are achieved while maintaining consumer safety and quality care.
Cross-cutting theme	Clinical governance	<ul style="list-style-type: none"> Effective clinical governance is a critical enabler for safe and effective implementation. Potential expanded role for government in supporting clinical governance in the primary health care sector.

Theme	Key Finding / Reform Option	Description
Cross-cutting theme	First Nations voices	<ul style="list-style-type: none"> Stakeholders representing the First Nations health sector were generally supportive of the intent of the review in seeking to strengthen multidisciplinary team-based care, and reiterated the message that this reflected the way primary health care is delivered effectively in ACCHO settings. Stakeholders warned against perceived assumptions the ACCHO model could be 'scaled up' in absence of the specific governance mechanisms, the local context and cultural underpinnings of this model.
Cross-cutting theme	Consumer voices	<ul style="list-style-type: none"> Consumers were primarily concerned with issues which have a material impact on their experience accessing primary health care, including consumer choice, affordability and accessibility of health services. Consumers urged that people with lived and living experience should have a critical role in informing the development of all reform options.
Workforce design, development and planning	1. Skills and Capability Matrix and Framework	<ul style="list-style-type: none"> Stakeholders indicated general support for this reform as providing a foundation for skills-based primary care and interprofessional trust. A transparent, inclusive approach should be taken to develop the Matrix. The Matrix could be useful to a range of stakeholders in meeting community need. It is essential the Matrix is dynamic and accessible.
Workforce design, development and planning	2. Develop primary health care capability	<ul style="list-style-type: none"> This reform received a high level of support from the majority of stakeholders who recognised the need to improve the perceived value of primary care specific education and training. Provision of quality supervised practical training (or 'placement') opportunities in primary care was viewed almost universally by stakeholders as critical.

Theme	Key Finding / Reform Option	Description
		<ul style="list-style-type: none"> Addressing existing barriers to the provision of quality placement experiences in primary care was viewed as critical. Establishing a skilled and valued supervisor workforce was viewed as essential to quality training experiences in primary care. Mandating supervised practical training in primary care, although acknowledged as a potential contributor to reform, was considered unachievable and not favoured. The development of collaborative skills (through interprofessional education and other collaborative experiences) was viewed as a foundational expectation for all health professionals.
Workforce design, development and planning	3. Early career and ongoing professional development includes multi-professional learning and practice	<ul style="list-style-type: none"> Universal support to provide health professionals who work in primary health care with the resources to maintain and enhance their skills. Access to affordable, modular education and training to support development and maintenance of primary care skills and capabilities considered critical. High level of support for the establishment of greater consistency and availability of mentorship and peer support and/or coaching across the career continuum. Stakeholders viewed multiprofessional learning as important to developing the multidisciplinary team, but expressed opposition to this being mandated as part of continuing professional development programs instead preferring it to be incentivised.
Legislation and regulation	4. Risk-based approach to regulating scope of practice to complement protection of title approach	<ul style="list-style-type: none"> Overall support voiced for this reform option, contingent on it being a complement to, rather than replacing, protection of title. Stakeholders preferred 'activity-based' to skills-based regulation and a focus on community need rather than solely on high-risk activities.

Theme	Key Finding / Reform Option	Description
		<ul style="list-style-type: none"> Some stakeholder groups raised concern about a perception that activity-based regulation could be reductive in treating primary care as a collection of defined activities, and in being silent on areas of primary care outside of these activities, may unintentionally devalue some of the work primary health care professionals do. Need to reinforce and strengthen clinical governance arrangements to promote safety and quality of care.
Legislation and regulation	5. Independent, evidence-based assessment of innovation and change in health workforce models	<ul style="list-style-type: none"> High level of support and enthusiasm for this reform option, as filling a critical gap in supporting health workforce reform in the primary health care system. Overall consensus that this mechanism should not be housed within Ahpra, but should be national in order to hold an overarching role across professions. Should be broadly representative and non-hierarchical to avoid driving specific agendas.
Legislation and regulation	6. Harmonised Drugs and Poisons regulation to support a dynamic health system	<ul style="list-style-type: none"> Overall strong support for this reform option voiced across professional groups despite the perceived implementation challenges. Many participants supported a staged approach to harmonisation that commenced with relatively lower-stakes consensus-building activities. Strong support for additional harmonisation efforts including radiation safety.
Funding policy	7. Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice	<ul style="list-style-type: none"> Broadly positive response to the concept of moving towards a blended payment model in primary health care, provided it has a well-designed and realistic risk stratification mechanism. Representatives of allied health professions raised concerns about the lack of a specific mechanism for funding availability and

Theme	Key Finding / Reform Option	Description
		<p>transfer outside the consumer's main general practice.</p> <ul style="list-style-type: none"> • Mixed support for a single payment rate for like services provided by a range of professions. Difficult to isolate the specific service provided from the context of the broader clinical encounter, and different skill sets of providers. • Broad consensus that a bundled payment for midwifery continuity of care maternity service model would be of significant value in resolving scope of practice issues specific to this workforce. There are opportunities to expand into other condition or treatment pathways such as diabetes care.
Funding policy	8. Direct referral pathways supported by technology	<ul style="list-style-type: none"> • Significant support from both consumers and non-medical professions on the basis it would address scope of practice issues and improve access. • Mixed support from medical professionals due to concerns about the potential for fragmented or episodic care. • Broad agreement that an instant notification and communication mechanism was crucial to maintain care integration across the multidisciplinary team and ensure the safety and effectiveness of this reform option for consumers.

6.2 Next steps

This stakeholder engagement report will contribute to the development of the Draft Final Report, which will undergo further consultation during Review Phase 4.

The Final Report is due to be provided to the Minister in October 2024.

7 Appendix A: Summary of Phase 3 consultations

The below table summarises the face-to-face and online consultations held during Phase 3 which informed this report. A total of 235 participants took part in 10 consultation sessions (7 face-to-face and 3 online).

Table 3: Summary of Phase 3 consultations

Type	Location	Dates	Number of participants
Face-to-face consultation	Brisbane	11 June 2024	25
Face-to-face consultation	Brisbane	12 June 2024	20
Face-to-face consultation	Melbourne	13 June 2024	24
Face-to-face consultation	Melbourne	14 June 2024	29
Face-to-face consultation	Canberra	24 June 2024	31
Face-to-face consultation	Rural and Remote (Canberra)	25 June 2024	33
Face-to-face consultation	Expert Advisory Committee (Canberra)	26 June 2024	21
Online consultation	First Nations	Session 1: 17 June 2024 Session 2: 20 June 2024	9 (Note: participants at Session 2 were a subset of Session 1 participants)
Online consultation	Consumer	17 June 2024	26
Online consultation	Rural and remote	28 June 2024	17

8 Appendix B: Summary of Phase 3 survey responses

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

Table 4: Distribution of Citizen Space survey respondents – Individual

Individual Category Distribution	% of all responses
Health Professional/Worker	45% (n=54)
Consumer or Carer	13.3% (n=16)
Other	0.8% (n=1)
Total	58% (n=70)

Note: 49 (40.8%) respondents did not provide a response to this question

Table 5: Distribution of Citizen Space survey respondents – Organisational

Individual Category Distribution	% of all responses
Health Service	2.5% (n=3)
Peak Body	14.2% (n=17)
Government	1.7% (n=2)
Regulator	0.8% (n=1)
Professional Association	12.5% (n=15)
Other (includes 5 responses from educators)	10% (n=12)

Individual Category Distribution	% of all responses
Total	42% (n=50)

Note: 70 (58.3%) respondents did not provide a response to this question

The following table summarises response rates for each of the online survey questions. A total of 120 responses were received.

Table 6: Phase 2 Citizen Space survey response rates per question

Question no.	Question text	No. responses	Response rate
1	What leadership do you consider important to ensure reforms are successfully implemented? For example, what is required at the professional, practice, organisation and/or profession level?	110	92%
2	To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?	114	95%
3	To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice? Leadership requirements comments	86	72%
4	How should the National Skills and Capability Framework and Matrix be implemented to ensure it is well-utilised?	101	84%
5	Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care? Who will provide leadership to ensure the framework is effective?	94	78%
6	To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?	113	94%

Question no.	Question text	No. responses	Response rate
7	To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice? Additional comments.	68	57%
8	To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?	108	90%
9	To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances? Additional comments.	60	50%
10	What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective? Are there specific policy actions related to legislation and regulation you believe should be pursued?	86	72%
11	To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?	110	92%
12	To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice? Additional comments	78	65%
13	What other implementation options should be considered to progress the policy intent of these options for reform? Will combined options for reform address the main funding policy issues?	67	56%
14	What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of these policy options? Are there implementation options which have not been considered?	74	62%

Question no.	Question text	No. responses	Response rate
15	Are there additional reform options which have not been considered that could progress the intent of this Review?	68	57%
16	Are there additional considerations which have not been raised that could progress the intent of this Review?	48	40%

