AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | ama@ama.com.au
W | www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA Submission to Scope of Practice Review—Issues Paper #1

scopeofpracticereview@health.gov.au

The AMA has appreciated the extensive consultation on this Review to date. We commend the review team on the efforts to engage with all relevant stakeholders across multiple fora. The AMA is confident that the review team has heard the concerns of AMA members—views that have been expressed by many medical groups throughout the review. What we have not seen in Issues Paper 1 is an attempt to genuinely address these concerns.

Concerns about safety and standards, about the significant gaps and loopholes in our regulatory systems, and about fragmentation of the health system are not trivial. The Review must acknowledge and address the concerns to ensure the continued support of the medical profession.

Australia has strong collaborative models of care—the AMA highlighted some of the better models in our initial submission. Australia's doctors want to work collaboratively and they want funding models that will support and allow this. They also understand that excellent health care is best facilitated when team members receive excellent education, training, continuous professional development, understand and support each other's roles and are supported to deliver the best possible work within their scope in the best interests of the patient and the community.

The Reviewers highlight the importance of interprofessional trust frequently in the paper. This is indeed an important driver for collaborative care and in engendering support for health professions working to full breadth of scope or pilot the expansion of scope. There are many positive examples of pilots and studies within Australia that have demonstrated this. We have also seen examples where there is no collaboration, there is no consultation and as a result interprofessional trust has been undermined.

AMA members continue to express concerns about the direction of the review. The AMA has in the past proposed a sensible, simple independent process that allows a proper and robust cross profession assessment of proposals for expanded scopes of practice. The AMA would be supportive of a process where it can be determined that:

- the required competencies are predetermined, and accredited training and education programs are resourced and available to deliver those competencies

- there are documented protocols for collaboration with other health practitioners
- the safety risks for patients are minimised
- the change in scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models
- the training opportunities for other health practitioner groups is not diminished/ the impact on training and education of all professions involved is considered, including the impact of adding training and supervision roles and access to clinical experience
- the cost to the health care system will be lower than the current service offering, taking account of education, training and supervision and governance costs
- risk analysis and governance models that ensure ongoing evaluation of quality patient outcome, impact on the professions and health system as a whole and cost will be incorporated and funded into any new model of care.

Despite the early assurances of the Reviewers that there would be a focus on processes, we are yet to see any real proposals that come close to a model like this. Building a process like the one above and including nationally consistent structures as outlined below will ensure Australia's health system continues to deliver world-leading outcomes while ensuring safe and consistent standards across professions.

Theme 1: Legislation and regulation

The AMA strongly supports the harmonisation of drugs and poisons legislation across states and territories, as well as the harmonisation of protected titles. An appropriately trained and credentialled health professional should be able to perform the same task with the same title across Australia. Unfortunately, we do not believe this is a feasible outcome.

The lack of harmonisation of drugs and poisons legislation is undermining the work of our regulators; when independent advisory bodies like the Pharmaceutical Benefits Advisory Committee and the Advisory Committee on Medicines Scheduling cannot be certain who can prescribe and in what context across jurisdictions, it becomes difficult to advise.

The Reviewers have begun to address these issues with this 'opportunity' on page 14:

> "Acknowledging the overlapping nature of scope of practice through legislation and regulation, such as through a more risk-based and/or activity-based process of regulation. This would involve shifting scope of practice regulation to focus on specific activities, then mapping to health professionals who are already competent (or could become competent) to perform that activity (task-based regulation process), rather than solely through named professions."

The problem with limiting it to activity is that it will ultimately undermine collaborative approaches as opposed to supporting them. The scope of a health professional will vary dependent on the environment that care is being delivered in. A better approach is to determine scope by activity and setting, based on training and experience with direct reference to the Poisons Standard.

A potential structure which we would like the Reviewers to consider is the establishment of a national scope of practice register. The purpose of the register would be to address all of the components suggested above.

The register notes basic qualification then any additional relevant training or experience. If this includes a scope extended beyond the basic qualification, this is noted along with any protocols that facilitate this.

The next level which would begin to address some of the concerns the AMA has previously raised as well as difficulties raised in Issues Paper 1 would be linking directly any prescribing directly to the Poisons Standard. This would ensure that medicines regulation through the Therapeutic Goods Administration and its advisory bodies knows who is prescribing what and in what context. This would require the cooperation of the National Boards and the Australian Health Practitioner Regulation Agency (Ahpra).

The body responsible for maintaining and updating the register as well as for data collection must be a Commonwealth body, not an instrument of the National Law to ensure that the Minister for Health and Aged Care and their delegated authority within the Department are properly accountable.

There are already processes in place through the National Registration and Accreditation Scheme (National Scheme) to allow health professions to change scope, so that work would not need to be repeated. However, the AMA would expect that any proposal to expand the scope of a professional group would demonstrate positive results for:

- Patient safety
- patient health outcomes
- cost effectiveness
- impact on workload for other health professionals
- impact on general practice and emergency department demand—patient flow through primary and community care and the acute system
- impact on Medicare and the Pharmaceutical Benefits Scheme
- the effectiveness of education, training, and accreditation and the links to quality of care
- the effectiveness of regulations
- The patient safety priority of clarity and transparency for patients and the community of education, training, qualifications, credentialling and scope for health care providers.

These were raised in the AMA's first submission.

A potential risk of this proposal is that it facilitates micro-credentialing. This process must not become a structure that requires diplomas or mini-qualifications for every single skill or area of expertise a health professional has, rather it would note specific high-level advanced skills. For example, the Society of Hospital Pharmacists of Australia has commenced a specialisation program for hospital pharmacists through the Australian and New Zealand College of Advanced Pharmacy. This is a positive model which will allow pharmacists to extend their skills into specific areas of treatment. The register could work in a way that would see the

pharmacist have their new specialisation added to the register, noting any additional scope is within the hospital setting and linking back to the Poisons Standard.

One of the major unacknowledged challenges with the regulation of health professionals in Australia and the National Scheme, specifically is the role that Health Ministers collectively play in determining policy directions through the Health Ministers Meeting. When the process of this meeting changed from the Council of Australian Governments Health Council during COVID-19, the level of transparency reduced significantly.

Even if this meeting were to commence acting in a transparent manner by forecasting upcoming meetings including the agenda and releasing more than the often single-page communiques in the aftermath, the structure itself lacks the level of accountability that Australians expect as there is no single source of authority.

One example is the failure of the Health Ministers to progress the inclusion of sonographers to the National Scheme. The AMA has written to the Health Ministers on multiple occasions supporting the advocacy of the Australian Sonographers Association to have their profession regulated under Ahpra and the Medical Radiation Practitioner Board, but the Health Ministers seem unconcerned.

The AMA does not have a proposed solution to this issue.

Theme 2: Employer practices and settings

While Scope should not be dependent upon employer, scope can be and often is dependent on workplace setting, context, workplace model and protocols, other health professional working in the same service, and available resources. The model proposed in theme one addresses this and would address some of the points raised under this theme, specifically the goal to allow health professionals to use their skill regardless of employer. It would also facilitate the interprofessional trust suggested by the Reviewers.

This would address many of the concerns the AMA has with the direction of scope of practice in Australia—while the review continues to insist this is about building multidisciplinary models, many of the proposals and submissions outline proposals to simply perform more GP-type work outside of collaborative models, and in some cases argue that they need less training, experience or accreditation to do so.

The AMA has repeatedly highlighted the types of collaborative models which allow non-medical health professionals to work to full breadth of scope in a safe and beneficial way. For example the Hand therapy clinics run in Victorias. Hand therapy led clinics in public hospitals, connected with and driven by surgeons, have been run for almost twenty years, and involve hand therapists working at full breadth of scope, managing patients with specific clinical conditions in accordance with evidence-based protocols, supported by medical staff.[1]

The AMA remains concerned that the feedback from some of the non-medical groups does not acknowledge the importance of collaboration and continues to push for expanded scope to work in isolation with access to prescribing.

[1] Monash Health – Hand Therapy: https://monashhealth.org/services/allied-health/occupational-therapy/hand-therapy/; Sobb, J.-A., Tharakan, C., & Beazley, J. (2022). Allied health led post-operative hand clinic: Evaluation of an alternative model of care. *Australian Occupational Therapy Journal*, 69(1), 77–88. https://doi.org/10.1111/1440-1630.12771

Much of the feedback from these groups—and from the reviewers too—outlines how they want to ease the burden on general practice by taking the "easy work" performed by GPs, allowing them to focus on more complex care. The reality is that GPs are already performing much more complex care than they were even a decade ago. Strategies to increase access to general practice should be fundamentally guided by the expertise of GPs—including where facilitating full scope of practice of other health professionals working in collaborative multidisciplinary GP-led teams would be most effective.

When we surveyed AMA members about the biggest challenges they face in their role, the increasing complexity of care was one of the major challenges identified. This is likely one of the causes of the emerging trend in GP MBS item data is showing a shift away from shorter consults (Level A and B) to longer consults (Level C and D).

This is one of the key reasons the AMA has been so strongly in favour of collaborative models and appropriate funding for them, because care is already complex and requires the support of practice nurses, pharmacists, psychologists and other health professionals.

Theme 3: Education and training

This section has positive suggestions and options for progress. The AMA agrees with and supports the need for consistency across professions for education, training and the process for endorsement. However, the AMA remains concerned that the Review continues to see all "barriers" as obstacles to be removed rather than as potential safeguards in our system. We do not mean to imply that all barriers are appropriate and we do support consistency, but it is appropriate for there to be minimum practice hours required for endorsement, and it may be a concern that there are some processes that do not have this. Maintaining Australia's high standards of education training and supervision for all of the professions must be an objective of the Review. This contributes to the quality of care delivered, efficiency and cost effectiveness.

We look at the example of general practice. Four to six years of medical school, at least two years of prevocational training, then another three to five years as a registrar of one of the GP Colleges. This is a robust process which ensures Australia has some of the best primary care doctors anywhere in the world. While there is a current GP shortage in Australia, the AMA would never support proposals to compromise quality and safety.

We cannot look for shortcuts to address the shortages we are seeing across the entire health workforce. Rather, we need structures to ensure consistency in training, support for training to be made available, and a structure to ensure we know everyone is working to full breadth of their scope that encourages health professionals to work in the environments we need them in.

Compromises to quality of training can result in compromises to performance, increased unnecessary investigations, double handling of patient care issues, increased levels of supervision required and increased costs and decreased efficiency in addition to decreased safety and worse patient outcomes.

There will be costs associated with increased education, training and supervision. The AMA recommends the Reviewers conduct a proper analysis and costing of the required increases and impacts of this education, training and supervision on all professions and the health system as a whole.

Theme 4: Funding policy

The AMA is supportive of block funding models such as the Workforce Incentive Program (WIP). Unfortunately the WIP was not indexed until the most recent Federal Budget and remains too low to be meaningfully used. General Practices often need to fund nursing and allied health staff through the billing of patients by doctors. Costs need to be transparent for patients and the community—and the clarity for patients of the scope of practice and education, training and qualification of health care providers needs to be maintained.

The AMA is also supportive of further discussions around expanding MBS item numbers for practice nurses to facilitate the use of nurses and make general practice a more attractive place for them to work.

It is important that the role of the Medical Serviced Advisory Committee remains and all new MBS item proposals or proposals for significant public funding of healthcare are independently reviewed.

One of the most significant concerns not addressed is the impact on indemnity. The AMA has discussed this review with Medical Defence Organisations who have shared concerns that there has been no engagement with their questions and concerns regarding the potential impact on medical practitioners indemnity insurance. Medical indemnity is already a significant cost for medical practitioners, with some specialties paying well in excess of $100,000 per year.

The AMA would like to see the Reviewers specifically address indemnity in the next Paper. This was also a concern raised directly by members at the AMA webinar in January.

Theme 5: Technology

Technology should already be a tool that facilitates collaborative team-based care. The AMA is supportive of the Action Plan within the Digital Health Blueprint. A key driver will be interoperability with important work underway through the Sparked FHIR accelerator project. While there are some areas of this which we would like to see faster progress on, such as the introduction of procurement standards, in general we see this progressing well.

As the Reviewers note, Australia's digital health infrastructure is far from the level of maturity to support the goals and models in the paper. Collaboration cannot be reduced to merely uploading patient records to My Health Record in its current format which is little more than a repository of pdfs.

One area where technology should be used more actively and transparently is in governance and audit reporting on current scope expansion trials. It is unclear if anyone is counting the number of antibiotic prescriptions in Queensland since urinary tract infection prescribing through community pharmacies was introduced which is vitally important to understand from both a funding and public health perspective.

General comment

The AMA remains concerned that some of the models referenced in this paper are models developed in health systems which are under a level of strain not experienced in Australia. While we appreciate the response provided to questions on this by Prof Cormack at the AMA webinar on 30 January—essentially that a good model is not dependent on the system it emerges from—the AMA contends that the context it emerges from must be considered in assessing it. The NHS for example is in a state of critical workforce shortage with extensive

backlogs. The United Kingdom has 3.2 doctors per 1000 people. Australia is still sits above the OECD average at 4 doctors per 1000 people.[2] The AMA is not arguing that we are not experiencing workforce pressures, but when looking to the NHS for models of care we must contextualise appropriately.

We also note that many of the stronger models outlined in the AMA's submission and supplementary submission were not included. In particular, Nuka System of Care in Alaska. This model uses elements of the patient-centred medical home model, with multidisciplinary teams (termed 'teamlets') providing integrated services in primary care settings and the community, coordinated with a range of other services.[3]

The 'teamlet' consists of four healthcare professionals:

- general practitioner: primarily responsible for the initial assessment and diagnosis, overseeing the development of treatment plans, and advising and reviewing plans when there is a change in conditions
- nurse case manager: triages, coordinates care, supports the development of care plans, monitors against the care plan, and provides education on how to manage conditions
- case management support staff: schedule appointments and build relationships with patients, and also work with nurse case manager on prevention and population health
- certified medical assistant: manages the daily schedule, greets patients, sets up examination rooms, and also carry out tests and screenings.[4]

Pharmacists, dieticians, behavioural health consultants, psychiatrists, midwives, and other healthcare professionals are used depending on patient needs. Healthcare professionals work to the full breadth of their scope within these teams, for example, pharmacists perform medication reviews, support patients to manage multiple prescriptions, and provide repeat prescriptions.

The Nuka System of Care is widely regarded as a very successful models of care, improving patient outcomes while also reducing pressure on hospitals and general practitioners.[5] The Nuka system has led to significant savings which have been reinvested back into other areas.[39]

Finally, while we understand this review is focused on primary care, the AMA is concerned that the conclusions of this review will represent the end of discussion on scope of practice and many of its recommendations will simply be translated across to the rest of the health

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[2] OECD (2023). *Health at a Glance 2023: OECD Indicators.* Doctors (overall numbers).

[3] Collins, B. (2015). *Intentional whole health system redesign. Southcentral Foundation's' Nuka'system of care.* London: The King's Fund. Retrieved 03/10/2023 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/intentional-whole-health-system-redesign-Kings-Fund-November-2015.pdf

[4] Breadon, P., Romanes, D., Fox, L., Bolton, J., & Richardson, L. (2022). *A new Medicare: Strengthening general practice. Grattan Institute.* Retrieved 12/10/2023 from: https://apo.org.au/sites/default/files/resource-files/2022-12/apo-nid321019.pdf

[5] Gottlieb, K. (2013). The Nuka System of Care: improving health through ownership and relationships. *International journal of circumpolar health, 72*(1), 21118. Doi: 10.3402/ijch.v72i0.21118

system. It is important that the unique structures and existing clinical governance models of our public hospitals are considered in any widespread changes to scope.

Contact

president@ama.com.au