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SUBMISSION

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AMA submission to Scope of Practice Review – Issues Paper 2

By email: scopeofpracticereview@health.gov.au

Introduction

The AMA is disappointed and frustrated by Issues Paper 2, which sets out potential reform options without anchoring these within a robust and coherent framework that would protect quality and safety, guard against fragmentation of care, encourage good models of care, avoid significant extra costs to the health system and recognise the need to support generalist practice. The paper is at times high-level and lacking in detail and in other examples overly specific in recommending models of care with no evidence.

The paper has no regard for the fundamental role of general practice and general practitioners and appears to set out reform options for the sake of reform. The evidence base for much of what is proposed is weak and the review has ignored material provided in good faith by organisations such as the AMA about new collaborative models of care that have been shown to work well in Australia.

There is a very real fear that the Review is intent on pursuing changes seen in other health systems like the United Kingdom, which all Australian's should fear given the declining performance of the UK health system.

The contents of this paper contradict reassurances provided by the Review including during consultation meetings; specifically the paper does set out to expand scope, it provides pathways for the development of models that will fragment patient care, and it continues to speak for GPs without referring to the overwhelming feedback from GPs that this is not what they want or need.

Where the Review has incorporated some of the AMA's advice we see the discussion of reforms that have the positive potential to support the primary care workforce. However, by continuing to ignore much of the input of the AMA and other medical bodies such as the Royal Australian College of General Practitioners, the Review is very close to losing the support and engagement of the medical profession.

This submission will outline our concerns and provide comments on the options for reform.

Concerns with the Review

The Scope of Practice review has fundamentally deviated from the objectives and recommendations of the Strengthening Medicare Taskforce Report. The Taskforce followed the release of Australia's

Primary Health Care 10 Year Plan 2022–2032, which set out a plan to support the reform of primary care built around the central role of general practice (as expressed in current government policy as MyMedicare) and high quality team based models of care.

It has also ignored the terms of reference for the project and taken an often-radical view of the foundations of Australia's health system, including the *Health Insurance Act 1973*.

It is frustrating for the AMA because we have put significant effort into engaging constructively with this review. AMA members took time out of clinical practice to attend fora earlier this year hosted by the Review. The AMA has hosted webinars, council meetings and brought the review team to the largest professional meeting of Australian doctors held in Australia earlier this year. We have provided submissions to all consultations and even provided an additional literature review to aid the review team which highlighted many successful collaborative, multidisciplinary models of care where non-medical health professionals work to their full breadth of scope. We have not only failed to see this acknowledged in any of the papers to date, we have not seen any models that look at general practice-led models of multidisciplinary care or propose collaboration.

Indeed, across Issues Papers 1 and 2, there is not a single mention of GPs or general practice that does not frame them as an obstacle.

The AMA can only conclude that there is no intention to work with GPs, and no intention to integrate nurses, physiotherapists, psychologists and pharmacists into the primary care team.

The other frustration is the continued ignorance of what scope actually is. The AMA has identified numerous models outside the primary care system where other health professionals work to full breadth of scope. Fundamental to these models are the structures around them that make them safe and effective. Scope does not follow the individual; it is determined by members of the team, the credentialing of all involved, and the training and experience of individuals. The Review has come close to acknowledging this, but never stated it clearly enough that this will be understood once the final report is handed down.

We believe that the Review can still address many of the AMA's concerns. However, the reviewers must also make an effort to show general practice that they have listened to the suggestions and the concerns of GPs. To achieve this, the language must stop implying that GPs are an obstacle, making statements about how non-medical practitioners can support GPs by taking "low level GP work" while disregarding the feedback GPs have provided and actually explore collaborative models of multidisciplinary care within general practice that enhance access to care and use the full breadth of scope of the primary care team. This does not mean the Review must only talk about general practice, but this clearly is a deficit that needs to be rectified.

Options for Reform

Some of the options for reform proposed in the Paper have positive potential with some refinement. The options under the Workforce design, development, and training theme are headed in the right direction. There are also some positive elements to the proposals under the Legislation and Regulation theme. The AMA has significant concerns with proposals under the Funding and Payment policy theme. These are explored below.

Theme 1: Workforce design, development, and planning

Option 1 - National skills and capability framework and matrix

The AMA would like to see far more detail on framework and matrix, however we are open to further discussions on this proposal provided it addresses some key issues. Beyond lack of detail, the main issue is that it does not appropriately acknowledge that scope should not be determined solely by the health professional, but by the setting in which they work. A qualified, experienced health professional working to their full breadth of scope in a collaborative model in a health setting with medical oversight or support should have a different scope when working independently without support. From a risk-based approach, this is a sensible adjustment to the model proposed as it promotes collaborative models and patient safety as opposed to fragmentation and increased risk to patients.

As noted in our submission to Issues Paper 1, any framework that sets out scope should refer directly to the Poisons Standard if the scope is to include the prescribing of medications. This would ensure that medicines regulation through the Therapeutic Goods Administration (TGA) 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.

The AMA reiterates that we expect 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
- improving clarity and transparency for patients and the community of education, training, qualifications, credentialling and scope for health care providers.

Workforce planning and community need assessment should be conducted by an Independent Health Workforce Planning and Analysis Agency (IHWPAA). The IHWPAA would be an appropriate body to oversee a health workforce capability framework and matrix.

Option 2 – Develop primary health care capability

The AMA supports developing and expanding the primary health care workforce. There are significant challenges that will require genuine investment to support the development of better training opportunities within primary and community care. One of the challenges which is not addressed is current workforce and supervisor availability. Efforts to increase meaningful training in general practice will require significant investment to improve practice infrastructure and supervisor availability. As evidenced by the yet to be implemented mandatory community terms within the AMC National Framework for Prevocational (PGY1 + 2) Medical Training Standards, there is no capacity to

increase learning within general practices in the short term in the absence of greater investment and support.

Option 3 – Early career and ongoing professional development includes multi-professional learning and practice

The AMA is broadly supportive of the proposals under this option. Many of the obstacles identified apply to AMA members. Again, education training and supervision must be costed and resourced.

Theme 2: Legislation and regulation

Option 4: Risk-based approach to regulating scope of practice to complement protection of title approach

The AMA agrees that scope should not be "tied to titles", but what the reviewers have again failed to properly acknowledge is that scope should also not be tied to the individual health worker. Scope is dynamic and will change for an individual based on setting. In an accredited health service working in a collaborative model with clear protocols in place, many of Australia's allied health professionals could be working at a higher level. We see this occurring in the tertiary care setting right now.

This is the fundamental flaw in the National skills and capability framework and matrix and the risk-based approach. The suggestion of an "activity-based approach" is the closest, however it must also ensure that there is some acknowledgement of settings that permit this activity. This will also ensure that it meets goals of ensuring collaboration as it is central to the scope. The AMA would also like more details on how boards would be engaged in the process and how disputes between boards on scope would be resolved.

The AMA notes the Paper includes many statements that frame the Health Insurance Act as a barrier to specific models of care. This is an odd perspective on the Act which broadly acts for a framework for the administration of Medicare and is regularly amended as health policy develops and our health needs evolve. The implication that it is the barrier preventing the creation of an MBS-funded pathway for a Registered Nurse instigating a mental health care plan (page 51) ignores the many factors that prevent that pathway from existing as well as pathways to allow it.

The AMA notes that it would be valuable if this review were to recommend work to clarify titles within health settings. This is a growing concern for AMA members.

Option 5: Independent, evidence-based assessment of innovation and change in health workforce models

The AMA remains supportive of independent, evidence-based advice determining the funding of healthcare services and delivery in Australia. With clear reporting and stakeholder consultation, bodies like MSAC and the Pharmaceutical Benefits Advisory Committee (PBAC) have generally ensured taxpayer funded healthcare has a strong evidence base and delivers value.

The AMA is unclear of the ultimate objective of this proposed body. The PBAC and MSAC work well because they have a clearly defined purpose and straightforward recommendations which go to the Minister for Health and Aged Care for consideration. Essentially, the advice is to fund or not fund a medical service or subsidise a medication. While the independent evaluation component is positive, it is unclear what format any advice would take, who it would be directed at, and how .

The AMA would be open to a model that would see a National Board approach the body with a proposal to expand scope. This would allow for consultation with all stakeholders, for the body to make a determination and advise the board on this conclusion. The board can then continue to regulate their profession based on this advice which can also be applied to any matrix or register.

Option 6: Harmonised Drugs and Poisons regulation to support a dynamic health system

As noted in our last submission, the AMA is strongly in favour of harmonising regulations across jurisdictions, however we do not agree that the main issue with inconsistent legislation is that it can "arbitrarily limit scope". The most significant challenge caused by inconsistencies across jurisdictions is the ability of state or territory health ministers to ignore nationally agreed prescribing pathways, the decisions of national regulatory boards as well as the determinations of the Therapeutic Goods Administration on medicines scheduling.

The reviewers have not provided any pathway for achieving this beyond asking health ministers to agree to beginning work on it. The AMA is not optimistic about the prospects of this. This is why the AMA proposed any structures like proposed skills and capability framework and matrix should refer directly to the Poisons Standard. This would limit the requirement for health ministers to be involved and would promote national consistency.

Theme 3: Funding and payment policy

Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice

The AMA has serious concerns with this section. The AMA has long called for greater block funding for multidisciplinary care within general practice, for example in 2014 the AMA highlighted the value of integrating pharmacists into general practice and called for an incentive payment to fund the model.

The recommendations under this heading provide minimal detail or evidence to explain why these recommendations are being made or what the outcomes will be while essentially proposing to reallocate significant pools of funding away from GPs and general practice while we are experiencing an acute GP workforce shortage and challenges attracting doctors in training into general practice training.

While the AMA remains supportive of blended funding models supporting multidisciplinary care, the suggestion that this should be funded in part by cashing out MyMedicare – among other programs – when the program has barely started would represent a tremendous retrograde step in the evolution of general practice.

The commentary about cashing out the WIP and PIP also veer outside the terms of reference of the Review, as it proposes cashing them out (implying there is an impact on scope) without in any way considering their effectiveness or efficiency.

The AMA has long advocated for the WIP to be strengthened and expanded as part of a plan to grow general practice as the foundation of primary care. It is disappointing that this opportunity to grow resourcing for general practice has instead been used to suggest dissecting and reassembling the funding for models of care which do not have any actual collaborative components.

The AMA fails to see how a single payment rate for specified activities or bundled funding for midwifery would in any way drive anything other than the fragmentation of care, moving more care away from general practice and a patient's usual GP. The recommendation is also oddly specific considering the mostly high-level recommendations that are lacking in detail.

This entire section belies the stated claim that the Review is about supporting collaborative, multidisciplinary care. Furthermore, it actively undermines efforts to reform and improve general

practice that the AMA, and other GP representative bodies including but not limited to the RACGP, ACRRM and RDAA have been working on for years.

Option 8: Direct referral pathways supported by technology to enable all team members to make referrals within their scope and improve access to care for consumers

The AMA does not support this option. The AMA can only see the challenges/risks identified on page 72 as outcomes of this reform. The cost of increased referrals and over-referring to the MBS would be significant. Furthermore, there is a risk that this will lead to over-specialisation within allied health professions which will inhibit access to generalised care.

This option is emblematic of a major flaw present throughout the paper: lack of evidence. Like anecdotes provided in the 'insights' boxes throughout the Paper, this section makes grand assumptions that the changes detailed would deliver some benefit without referring to any real evidence. The AMA would be open to genuine trials with strict protocols in place to assess the efficacy of reforms like those proposed within. The outcomes, risks and measures could be used to build the trial. It is likely there will be some positive findings, but it is just as likely there will be negative ones. These should lead to a refinement of models before potential implementation. The AMA is not supportive of the type of trials that are poorly designed and dismissive of negative outcomes which we have seen recently leading to new models of care being introduced without the usual, robust independent evaluation of an MSAC process.

Again, the review has steered away from exploring stronger collaborative models as a potential solution. There are models within hospitals where physiotherapists can refer directly to specialists, but these are again multidisciplinary models with strict protocols and errors can be nimbly resolved without wasting significant healthcare resources.

Enhancing multidisciplinary care in general practice

The Scope of Practice Review still has the potential to deliver meaningful reforms that will enhance multidisciplinary primary care and allow health professionals to work to their full breadth of scope right now.

The AMA highlighted two GP-focused models of primary care reform in The AMA's 10-Year Framework for Primary Care Reform in 2020. The Western Sydney Initiative and the Canterbury (New Zealand) Initiative focus on uplifting all members of the primary care team, successfully utilise technology to assist patients, and efficiently use healthcare resources in general practice to reduce hospitalisations generating significant savings.

The AMA's first two submissions to the Review also highlighted the Nuka model in Alaska, a 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.[1]

The AMA has also strongly encouraged the reviewers to look beyond the primary care system for successful models of collaborative care with non-medical health professionals working to their full

[1] 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

breadth of scope. The Partnered Pharmacist Medication Charting model[2] and the Hand therapy clinics run in Victoria[3] are examples of this. It is the collaboration and clear protocols that make these models work, not the individual health workers.

Another positive recent example is the Patient Care Facilitator trial in Queensland that will provide funding to coordinate care for newly-discharged patients to prevent readmission to hospital. This will involve funding for general practice nurses to:

- liaise with hospital discharge co-ordinators to ensure discharge summaries are returned to the GP more promptly and flag patients who need an urgent GP review
- contact patients, triage them, ensure they are aware of any discharge plans and book them in for a GP review as clinically indicated

Importantly, the model was co-designed and will be delivered in partnership by Queensland Health with the respective Primary Health Network (PHN), Hospital and Health Service (HHS) and local general practices.

AMA members have provided significant feedback throughout the Review on the multidisciplinary models used in their practices. There has been strong support for better funding for practice nurses – funding that would allow the nurse to work to their full breadth of scope either through specific MBS items or through meaningful pooled funding. There are many practices where practice nurses already do this but it is funded by the patient. A significant challenge AMA members continue to note is the increasing challenge to compete for nursing staff with other parts of the health system. Without proper funding general practice will lose nursing staff at a time when we can and should be increasing nursing roles in general practice.

General comment

The Review is failing in its core objectives of supporting collaborative models of primary care. There are small but simple improvements the reviewers can still make to address these, however time is of the essence. The AMA remains open to engaging, but we can no longer accept hollow assurances that this is not about expanding scope when the paper includes this as a mid-term goal, nor will we accept that it is about collaboration when the Paper offers nothing but fragmentary models that rely on cashing out core general practice funding.

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[3] Powerpoint – Jill Tomlinson, https://monashhealth.org/services/allied-health/occupational-therapy/hand-therapy/ , https://onlinelibrary.wiley.com/doi/epdf/10.1111/1440-1630.12771