RACGP submission to Unleashing the Potential of our Health Workforce – Scope of Practice Review – Issues Paper 2 (3rd consultation)

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RACGP

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RACGP submission to the *Unleashing the Potential of our Health Workforce* – Scope of Practice Review – Issues Paper 2 (3rd consultation)

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Department of Health and Aged Care's (DoHAC) independent Scope of Practice Review ('the Review'), led by Professor Mark Cormack. This is the RACGP's submission to Phase 3 of consultation – Issues Paper 2.

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 urban and rural members working in or toward a specialty career in general practice. The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support general practitioners (GPs) and their broader healthcare teams to address the primary healthcare needs of the Australian population.

Executive Summary

The RACGP remains concerned that the Review is undervaluing the benefits of continuous and coordinated care beyond the initial clinical presentation. The Review also appears to be deviating from the Strengthening Medicare Taskforce Report recommendations and the Review's own terms of reference and the evidence base cited is strongly skewed in favour of non-medical models of care. Scope of practice discussions must remain connected to GP-led multidisciplinary team-based settings that promote comprehensive, coordinated, continuous and collaborative care.

The Review frames healthcare as a commodity and regulation as a perceived barrier to the consumer obtaining their desired product. This simplistic framing misunderstands the principles of good primary care.

Issues Paper 2 continues to frame accessing GPs as a problem to work around by allowing other health professionals to work their full scope of practice; instead of recognising their role in providing high quality primary care. To date, there has been limited mention of the role of GPs in the context of specialist medical tasks in the review. Issues Paper 2 does not discuss this at all, despite this being part of the terms of reference. Instead, the Review focuses on reducing primary care to a series of shared tasks that can be undertaken independently by any health professional in any setting. There is a significant risk of health care fragmentation and inadequate comprehensive healthcare if it isn't underpinned by working in teams using the same health record.

The evidence in the review identified several key findings that correlate with the quintuple aim of healthcare improvement when health professionals are supported to work at full scope of practice. What appears to be missing is evidence around the technical clinical experience required for diagnosis, treatment, and management.

Future primary care should be designed to cater for complex issues, not simple one-off episodic care. GPs are the experts in longitudinal relationship-based care, whole patient diagnosis and management planning in primary care. The RACGP and its members have invested significant time to provide advice and feedback throughout the Review consultation processes. However**, concerns raised by the general practice community have not been addressed.**

General practice has been chronically underfunded for a decade. Much of Medicare financially rewards healthcare focused on short episodic illness, not prevention, or supporting patients to manage multimorbidity, or complex chronic illness or mental illness. The proposition to reallocate significant funding pools away from GPs and general practice (by cashing out Workforce Incentive Payments, Practice Incentive Payments and even MyMedicare) is very concerning and at odds with *Strengthening Medicare Taskforce* recommendations. This is particularly concerning because these payments are used to facilitate team-based care in general practice. The RACGP has recommended increases to Practice Incentive and Workforce Incentive payments and removal of artificial restrictions to PBS and MBS descriptors that unnecessarily curtail scope to enable a whole-of-practice approach to improving patient health outcomes. **RACGP's recommendations align to the Strengthening Medicare Taskforce Report recommendations.**

RACGP's general comments about discussion (pp1-27) of the consultation Issues Paper 2

1. Balance of evidence is disproportionate to general practice.

The RACGP holds strong concerns that the scale of evidence used as a base for the Review is heavily skewed in favour of non-medical models of care. The underlying bias in the evidence used bears itself in the tone, perspectives, and focus of the Review.

Scale of evidence per country and profession

Main countries

Country	Number of sources
Australia/New Zealand	154
Canada	88
US	216
UK	75
Western Europe	27
Multiple/ international	23

Main professions

Profession	Number of sources
Doctor/GP/physician	130
Midwifery	84
Nursing	532
Pharmacy	211
Physiotherapy	60
Social work	119

2. Primary Care is defined as the entry level/first and most regular encounter with the health system.

The '*Glossary'* and the opening paragraph Issue Paper 2's '*Executive summary'* provides this as the Review's definition of the primary care workforce. This is important because in the section on '*Benefits of full scope of practice'* (p 23), all the benefits are those of Barbara Starfield's features of primary care – i.e. the **evidence** that these benefits are obtained through care that is:

- first-contact access for each need
- long-term person- (not disease) focused care
- comprehensive care for most health needs
- coordinated care when it must be sought elsewhere.

In other words, care that is delivered in the community won't, as a by-product of the setting, deliver these outcomes; and care that is delivered by a range of practitioners working to full scope of practice **outside the context of a system of care designed around those features of primary care** is very unlikely to deliver those outcomes, no matter how strongly consultation participants "believe" it to be so.

3. GPs currently see over 90% of the Australian population each year, many more than any other health professional.

Every year 22 million Australians see a GP for their essential health care, making GPs the most accessed health professional in the country. On average patients receive 7.9 episodes of care from their GP throughout the year. Many of these presentations are varied[1] and/or undifferentiated symptoms, which can be/ are managed without onward referral, or without medication. GPs are often mentioned as gatekeepers, and this can be presented as a negative. There are positive aspects to having GPs undertake this largely unpaid aspect of their role, it helps ensure the people who need the services are prioritised to access the limited health resources and lengthy waiting lists, and it reduces overall health system costs. All health professionals have a lack of visibility over the patients they do not see. Assumptions about appropriate management of all people based on who they are currently seeing may not be accurate, as they currently see a patient cohort that is most appropriate for them, selected by GPs. The GP's holistic understanding of a patient's needs and priorities supports them to refer patients to the most appropriate health professionals. A gate keeping

role is appropriate due to the level of expertise that GPs have in triaging patients (relates to patient risk). Triaging is best done by a clinician with wide and/or long experience (ED triage is done by an experienced ED nurse). Directing undifferentiated patients to clinicians with limited skill sets negates the process of correct triage (this goes to the referral questions also).

4. **Reaching a diagnosis is not a simple step, especially with the presentation of undifferentiated symptoms or in the presence of multimorbidity.**

Multidisciplinary care works best once the establishment of diagnosis or differential diagnosis has occurred. Physiotherapy of course is the best place for back pain, except when it turns out to be metastatic prostate cancer, or myeloma or a presenting symptom of depression. GPs still need to be the practitioners who do the early assessment of presenting, undifferentiated symptoms.

A health system that prioritises the convenience of patient choice about the best provider will inevitably need increased capacity, be more expensive, with worse outcomes. The result will be unnecessary appointments and investigations, funded by the Federal Health budget to see an increased number of people.

There will be knock-on effects of health equity. Rates of potentially avoidable deaths are higher in the lowest socioeconomic group compared to the highest socioeconomic group. Diabetes, coronary heart disease and stroke are more than twice as common among adults in the country's lowest socioeconomic group. This perpetuates cycles of poverty, and across generations. Those who really need to see a provider are either priced out of the system due to increased demand with limited availability and/ or have increasingly prolonged waiting list.

There's a risk that the critical work of the Choosing Wisely campaigns and antibiotic stewardship is undermined.

5. **What every policy recommendation in the scope of practice review should consider.**

- Does it enhance the ability of the health care system to provide the features of primary care?
- Does it enhance the ability of the health care system to manage undifferentiated problems before a diagnosis is reached?
- Does it enable patient-centred care to manage multimorbidity, complexity and social and cultural contexts?

RACGP feedback on Options and Consultation questions.

The RACGP has provided feedback on the options provided in Issues paper 2, and has responded to the consultation questions, both of which can be found at **Appendix 1**.

RACGP's comments about the characteristics discussed in Section 4: Options for reform

1. **Leadership and culture**

Teamwork is based on mutual trust. Trust between professions could be enhanced by shared clinical practice guidelines that are 'living' and present our best possible synthesis of evidence as applied to an Australian context. For example, a GP will want to know the physiotherapist in their team is applying evidence informed best practice methods and that the physiotherapy peak body is committed. GPs don't want to discover their patients are having back X-rays for low back pain in the absence of symptoms/signs of serious pathology.

2. **Clinical governance**

Note reference on p30 that suggests "…consideration should be given to compulsory compliance with the National Safety and Quality Primary and Community Healthcare Standards (NSQPHS)."

Clinical governance requirements are addressed in the RACGP *Standards for general practices* (the Standards) . The Standards have been utilised for 30 years and are an accepted framework of quality and safety that protect patients from harm and improve the quality of health services. 85% percent of general practices in Australia are accredited against the Standards. Practices are defined in the Standards and would include Aboriginal Community Controlled Health Organisations (ACCHOs) and any non-traditional model that is providing comprehensive care to a particular population.

The RACGP does not support any shift away from general practice to the Australian Commission on Safety and Quality in Healthcare's NSQPHS Standards. These are only applicable where profession-led standards do not exist.

3. Rural and remote considerations

Throughout Issues Paper 2 there is an assumption GPs are in short supply in rural and remote areas and that there are other health professionals waiting to perform these roles. It is worth noting the published workforce shortages of these other health professionals and not push aside the workforce gaps for these professions in rural and remote areas. It should also be noted that general practitioners in training are allocated to mandated Distribution Priority Areas to address workforce shortages. We are unaware of any requirement for other, non-GP practitioners to do the same.

Patient safety also means that just because a health professional is present in an area of need, that alone does not determine that professional's scope of practice.

There is a difference between the scope of practice of a professional group and the competency of any individual in that professional group at the upper limits for that profession. The essential professional obligation is to seek advice and help. A GP cannot suddenly perform caesarean sections because they are the available professional in the region. Similarly, prescribing doesn't become scope of practice for a pharmacist, especially because a jurisdictional government has deemed it so and bypassed the Therapeutic Goods Administration (TGA). There needs to be patient safety and accountability.

4. Culturally safe care

This is discussed on page 29 of Issues Paper 2, in the "Leadership and Culture" section, but nowhere else.

The discussion uses the term cultural safety with limited apparent understanding of what this would mean for the broader health sector (refer to the National health plan and Ahpra for more context). It is used as an introduction to a couple of comments about ACCHO models, particularly the "whole of person approach" and multidisciplinary teams, without mention of the community governance and accountability that leads to the success of this model. There is recognition of the importance of cultural safety for Aboriginal and Torres Strait Islander people in the health workforce.

Culturally safe care is an individual responsibility of all health practitioners. A collective and organisational responsibility needs specific strategies and outcomes if it's not to be unintentionally made worse by the broadening scope of individual health practitioners. This is especially true if full scope of practice results in task substitution rather than multidisciplinary team care, care is fragmented, with no ability to oversee cultural safety. The importance of Aboriginal and Torres Strait Islander health workforce and appropriate training for the non-Indigenous workforce is clear.

5. Relationship-based care

Issues paper 2 refers to improved patient experience of care, but frames this purely as "more accessible and efficient primary care services provided closer to home." (p37). This misses the fundamental importance of relationships – seeing a practitioner who the patient knows and trusts. Without making this explicit, there is a risk of having multiple providers seeing a patient, but the patient isn't sure of their role in their care.

Issue paper 2 portrays health as a transaction of convenience as opposed to this occurring in the context of a relationship, or coordination and communication (which is more than just a shared electronic record) between members of the health care team. Excluding consideration to the importance of relationship will disproportionately affect those who feel excluded from health services currently – including many Aboriginal and Torres Strait Islander people – and would run the risk of worsening health equity. This is due to underserved communities viewing relationships as a measure of quality of care more than convenience.

General feedback on the Scope of Practice Review and Issues Paper 2

1. Alignment of the Scope of Practice Review

The RACGP notes Issues Paper 2 has included discussion and options that are out of scope for the review as

a. the Terms of Reference

The Review's Terms of Reference stated that the role of general practitioners in primary care will be considered in the context of specialist medical tasks that could be delivered by general practitioners. There has been limited mention of the role of general practitioners in the context of specialist medical tasks to date in the review. Issues Paper 2 does not discuss this at all. The combined options proposed in Issues Paper 2 do not address RACGP's position that GPs be recognised as specialists and be paid the same as other medical specialists for doing the same work. This is particularly relevant in rural and remote areas where a GP may be the only provider offering a particular service.

The RACGP expects to see greater discussion, inclusion and understanding of the role of GPs and in the Review's recommendations.

b. the Strengthening Medicare Taskforce Report recommendations

Strengthening Medicare Taskforce Report Recommendation	Comment
1. Increasing access to primary care	
Support general practice in management of complex chronic disease through blended funding models integrated with fee-for-service, with funding for longer consultations and incentives that better promote quality bundles of care for people who need it most.	The Issues Paper 2 appears to lean away from fee-for-service. Fee-for-service must remain at the heart of general practice funding.
Support better continuity of care, a strengthened relationship between the patient and their care team, and more integrated, person-centred care through introduction of voluntary patient registration. This needs to be supported with a clear and simple value proposition for both the consumer and their general practice or other primary care provider. Participation for patients and practices needs to be simple, streamlined and efficient.	The RACGP is supportive of a fit-for-purpose model of voluntary patient enrolment (VPE) in Australia. The RACGP is continuing to work with government to support the successful implementation of MyMedicare to improve patient outcomes. It is important that the Scope of Practice review align with the need for continuity of general practice care via MyMedicare.
Develop new funding models that are locally relevant for sustainable rural and remote practice in collaboration with people, providers and communities. Ensure new funding models do not disadvantage people who live in communities with little or no access to regular GP care, and whose care is led by other healthcare providers.	Favouring role substitution instead of addressing GP workforce issues will disadvantage people who live in communities with little or no access to regular GP care. Telehealth technology enables GP involvement, even if a GP is not physically present in the community.
Strengthen funding to support more affordable care, ensuring Australians on low incomes can access primary care at no or low cost.	The Scope of Practice review has a strong focus on affordable access to care, not necessarily GP care. The RACGP strongly supports increasing access to affordable general practice care. The RACGP 2024-25 pre-budget submission contains a range of measures to address accessibility and affordability of GP care, that we would recommend be considered further by government, including as part of the scope of practice review.
Improve access to primary care in the after-hours period and reduce pressure on emergency departments by increasing the availability of primary care services for urgent care needs.	The Scope of Practice review should reflect the role of GPs and general practices in providing care after hours. Increased support via the General Practice After Hours Incentive Program would enable more practices to provide support for patients in the after-hours period, as would introducing MBS telehealth items for after hours (refer page 24 of our telehealth submission).

Strengthening Medicare Taskforce Report Recommendation	Comment
	Comprehensive care must be prioritised through timely clinical handover and efficient communication between healthcare providers. New after-hours services, including Medicare Urgent Care Centres (UCCs), should be integrated with existing facilities, including general practice. There is a risk of fragmented care and service duplication if access is prioritised at the expense of coordination and continuity.
2. Encouraging multidisciplinary team-based care	
Fast-track work to improve the supply and distribution of GPs, rural generalists, nurses, nurse practitioners and midwives, pharmacists, allied health, Aboriginal and Torres Strait Islander health workers and other primary care professionals.	The RACGP has a workforce strategy to increase GP workforce.
Work with states and territories to review barriers and incentives for all professionals to work to their full scope of practice.	Piloting and expanding the use of GPs with Specific Interests (GPwSI) within outpatient clinics in public hospitals to increase patient access to specialist outpatient care and facilitate integration/collaboration between primary and secondary/tertiary care. These schemes must ensure GPwSI receive appropriate remuneration and resourcing.
Increase investment in the Workforce Incentive Program to support multidisciplinary teams in general practice, improving responsiveness to local need, increasing accountability and empowering each team member to work to their full of scope of practice.	The Scope of Practice Review may contribute in part to this recommendation.
Increase commissioning of allied health and nursing services by PHNs to supplement general practice teams in underserved and financially disadvantaged communities.	It is important for any additional services to be placed within established general practices to support continuity of care and integrated care for patients.
3. **Modernising primary care**	
Better connect health data across all parts of the health system, underpinned by robust national governance and legislative frameworks, regulation of clinical software and improved technology.	The Scope of Practice Review may contribute in part to this recommendation. RACGP recommends increasing funding to the ePIP and also measures to ensure interoperability across general practice CIS and interfaces of Aged Care and Hospital systems.
4. Supporting change management and culture change.	
Learn from both international and local best practice and invest in research that evaluates and identifies models of high value primary care excellence.	A large body of evidence for general practice and GP-led care has been omitted for consideration in the Scope of Practice Review.

c. Measuring What Matters Framework

Indicator	Metric	Comment
Access to health services	Cost: proportion of people who at least once delayed or did not see a General Practitioner (GP) when needed due to cost.	Will there be a replacement or equivalent metric for other health services?
	Cost: proportion of people who at least once delayed or did not see a medical specialist when needed due to cost.	
	Wait times: proportion of people waiting longer than they felt acceptable for an appointment with a GP.	
	Wait times: proportion of people waiting longer than they felt acceptable for an appointment with a medical specialist.	
Access to care and support services	Unmet needs: proportion of people (aged 0-64years) living in households who receive aged care services and who felt their needs were not being met.	Will there be the ability to measure the impact of change in scope/tasks performed by all health professionals?
	Unmet needs: proportion of people (aged 65y years and over) living in households who receive aged care services and who felt their needs were not being met.	
	Quality: proportion of people with disability (aged 15-64 years) who were satisfied with the quality of assistance.	
	Quality: proportion of people (aged 65 years or over) living in households, who were satisfied with the quality of assistance.	

2. Glossary definitions in Issues Paper 2

The RACGP has considered the various definitions that were provided by the Review and our feedback on those can be located at **Appendix 2**.

Conclusion

The RACGP is concerned about the direction that the Scope of Practice Review is heading, with the role of GPs and general practice a glaring exclusion in the consideration of such significant reform in the Australian healthcare landscape. The options presented in Issues paper 2 appear to be deviating from the Strengthening Medicare Taskforce Report recommendations and the Review's terms of reference.

The RACGP will continue to advocate for quality care and patient safety, according to a strong evidence-base and medical training and experience. We were concerned to see that the Review frames healthcare as a commodity and regulation as a perceived barrier to the consumer obtaining their desired product which undervalues the benefits of continuous and coordinated care.

We look toward the draft final report and recommendations realigning to the objectives of the Review and the Strengthening Medicare Taskforce, acknowledging the critical role of GPs in multidisciplinary care, and enabling the profession to work to their full scope of practice.

References

[1] Watt, G. (2015) Discretion is the better part of general practice. *British Journal of General Practice*, 65(635), p. 306

Appendix 1

RACGP's responses to the proposed options and consultation questions, by theme

1. Theme – Workforce design, development and planning

RACGP response re: the proposed options 1-3

Option 1: National skills and capability framework and matrix

RACGP response

A National skills and capability framework and matrix could be an opportunity to document, amplify and reinforce the length and complexity of education and training undertaken by respective professions to understand practice within their scope. However, it has risks and challenges, particularly because scope should also be determined in the context of the settings in which health professionals work.

Considerations for change

- Issues Paper 2 suggests that members of a particular professional groups have the same skills and capabilities. Reducing skills and scope to a list of tasks does not capture how each of the parts integrate with clinical reasoning, decision making and the subsequent impact on care and outcomes for the patient.
    - For example, immunisation. Although delivered by multiple clinicians (such as doctors, nurses and pharmacists), higher risk immunisations and those where there is more legal risk or uncertainty (contraindications, previous potential anaphylaxis) are referred to GPs.
    - Immunisation is an opportunity to address other health issues e.g. childhood development, adolescent health issues and opportunistic screening.
- It is not clear who would be responsible for developing the framework and assessment of individual professional groups against it. It would be a risk to patient safety for it to be self-assessed by individual professional groups. The Dunning-Kruger effect (cognitive bias where people overestimate their abilities, thinking that they are capable of a task/role when they aren't) is a known phenomenon.
    - "No problem in judgment and decision making is more prevalent and more potentially catastrophic than overconfidence."[i]

A generalist skill set is fundamental for integrative best practice with lower health costs and optimal patient outcomes. What has not been addressed in Issues Paper 2 is the overlap of non-GP specialist roles with general practitioners' scope.

Option 2: Develop primary health care capability

RACGP response

There are well publicised healthcare workforce shortages across many professions. A strategy to develop primary care workforce capability is important and needs to begin in late high school, and within medical school and undergraduate training in other disciplines. Some medical schools have longitudinal placements in primary care (eg University of Wollongong). Success will be dependent upon the structures and support in place.

Considerations for change

- All health professions, governments and policy makers will need to prioritise primary care health workforce, otherwise it will not translate to early career professionals being interested in primary care as a preferred career option. This strategy must include focus on attraction of medical students to the general practice speciality.

- Supervising capacity is important and will need to be well supported especially considering the business model of the primary care landscape. For example, in general practice this relates to infrastructure costs and loss of clinical consultation availability.
- Enhanced workforce could be achieved by increases to Workforce or Practice Incentive Payments for placements, stipend payment which recognises the income variability in the initial years of GP training. and/or single employer models (where appropriate) to support transition of junior doctors to primary care training.

Option 3: Early career and ongoing professional development include multi-professional learning (MPL) and practice

RACGP response

In principle, the idea of multi-professional learning and practice is a good way of supporting interdisciplinary learning and understanding of respective skill sets. MPL could improve trust between professionals. Early education will be important in the student journey as will ongoing continuing professional development (CPD). RACGP agrees that it may be appropriate at times for multi-professional learning to occur at a pre-vocational and vocational training level.

Considerations for change

- MPL needs to acknowledge the private business model of primary care and the cost of delivering education within these models. For example, there is a stark contrast between the ability to attend educational activities between salaried employees (e.g hospital employees) and community small business or contractors working in a fee for service model.
- MPL needs to emphasise the different roles that professions have within the health system.

Consultation questions

1. Do you believe the combined options for reform will address the main policy issues relating to workforce design, development and planning you have observed in primary health care scope of practice?

- No. The consultation does not directly address the critical issues. There is no clarity to be able ascertain the impact, value and outcomes over the medium-long term without robust modelling. The Review frames healthcare as a commodity and regulation as a barrier to the consumer obtaining their desired product. This excludes the principles of good primary care.
- It is likely these reforms will have greater impact and lead to more options for allied health professionals than for GPs.
- This proposal will lead to patient confusion and presentation to the wrong health professional leading to:
  - delays in treatment due to re-referral
  - missed diagnosis as the provider may not recognise the issue is outside of their scope.
  - duplication of costs due to multiple presentations for a single issue.
- Evidence of long term cost-effectiveness and improvement in patient health outcomes is important and must be incorporated.

2. To what extent do you believe these policy options will help to drive the policy intent of the Review in supporting multidisciplinary care teams to work together to full scope of practice?

- There is strong support from the RACGP for the ongoing improvement of multidisciplinary care. However the GP must remain at the centre of the multidisciplinary team. General practices, including and outreach clinics, already demonstrate multidisciplinary team care, housing GPs, nurses, pharmacists and a variety of allied and other health professionals working under the same roof.
- Providing general practices with funding through a health governance model for additional services added to basic medical and nursing services could be a driver for greater diversity of health care. In addition, care coordination, case conferencing and other non-patient facing work will need to be adequately remunerated and incentives provided to promote collaboration.
- The RACGP is concerned Issues Paper 2 is not genuinely encouraging multidisciplinary team care which leads to the risk of fragmentation of care and amplifies poor health outcomes in vulnerable communities.

3. Are there implementation options which have not been considered which could progress the policy intent of these options for reform?

- The Review does not fully address the barriers that people with complex health needs, or those in vulnerable situations such as escaping domestic violence, may face when seeking to access services and workforce. To date, reform has primarily focussed on increasing the visibility of allied health providers.
- Addressing the pay disparity between GP and other non-GP specialties.
- Acknowledging lack of investment in the infrastructure required to support multidisciplinary care and learning.

4. Based on your experience, what features should a skills and capability framework have to ensure it is useful in practice?

- The framework should have an outcomes-based approach.
- The framework would be effective if:
    - there was an inherent structural recognition in its design that practice based evidence and experience guides protocol and the interpretation of both these information sources is the art of clinical medicine.
    - it includes an elaboration of context and complexity in assessment, perhaps described through case description. The descriptors in a scale from Novice to Mastery could be helpful.

5. How should the framework be implemented to ensure it is well-utilised?

- A well-designed framework needs to be easy to use, but not risk consumer confusion in accessing the appropriate health care professional.

6. What do you see as the areas where the framework will have the greatest impact on scope of practice?

- No comment.

7. How do you see the recognition of common capabilities and skills in the framework contributing to the delivery of primary care?
• In rural and remote areas this may lead to improved access to healthcare overall but only within a multidisciplinary team model, located either geographically or virtually. • It should be acknowledged that different professions may hold different common capabilities and skills. A key element within this framework needs to be differentiation between protocol driven capabilities and skills compared to professions that have had sufficient training to allow flexibility in their approach.
8. Who do you see providing the necessary leadership to ensure the framework achieves the goal of contributing to health professional scope of practice in primary care?
• GPs are the lynchpin in primary care and well placed to provide leadership. The paucity of GP mentions within Issues Paper 2 is disproportionate to the size of the workforce they represent within primary care. • Leadership would need to be independent of political influence. • The RACGP recommends leadership be apolitical, and that state and territory health departments should genuinely work with general practice as part of their health system as well. • True collaboration between the Commonwealth, State and territory governments in general practice would lead to improved health savings across the board and improved health outcomes.

2. Theme – Legislation and regulation

RACGP response re: the proposed options 4-6

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

RACGP response
• Risk-based approaches to regulation may sound reasonable, however caution is required when leaving patients to judge the quality, depth of experience and qualifications of each touchpoint within primary care. For example, currently patients can trust that the physiotherapist knows about assessing and rehabilitating musculoskeletal conditions. Should role definitions become blurred, there is a risk of a universal drop in trust for health professionals, which evidence shows is associated with poorer health outcomes.
• A risk-based approach as described in Issues Paper 2 risks over- simplifying patient care into a series of defined tasks. Diagnosis and clinical reasoning take decades of training and experience and is a critical component of decision-making.
• Another unintended consequence could be increased indemnity insurance fees for health practitioners.
Considerations for change
• There needs to be clear guidance around use of titles and clarity for health professionals and consumers.
• At the moment there is inconsistency and lack of parity in the requirements of various professions to undertake the same work, which will affect a risk management approach. For example,
  ○ The 12-month relationship rule for telehealth.
  ○ Conflict of interest. Eg pharmacists are permitted to both prescribe and dispense (eg. medicines and devices).
  ○ Audit and compliance via funding mechanisms such as MBS and PBS.
  ○ Quality assurance, including quality improvement as part of CPD, and accreditation of clinical services, as for general practice.

- it should be recognised that medical practitioners are required to complete more CPD hours in comparison to other professions.

Other comments

- *"The Health Insurance Act is particularly prescriptive about the requirement for a medical professional to instigate, oversee and approve activities performed by non-medical health professionals in a multidisciplinary care team setting, resulting in an overall medico-centric model of primary health care and restricted scope for most other professions."* P51

RACGP response: The Health Insurance Act (HIA) restricts the scope of practice of GPs – eg GPs can't request most MRIs (though a psychiatrist could request an MRI of the C-Spine or an ENT surgeon request an MRI of the hand and wrist) – and arguably, the HIA results in a secondary care centric model of primary care.

The quote suggests that the Review considers it undesirable for multidisciplinary care to operate in this way. There is a difference between professions within a team and those working independently outside of the team. The former has evidence for improved outcomes, but the latter does not. An example are when vaccinations are provided by nurses or by pharmacists. When this occurs outside of a multidisciplinary team, there is a lost opportunity to provide additional care – child health surveillance and assessment of developmental milestones for children, assessment of management of chronic diseases and other preventive health for adults under the National Immunisation Program . This can happen in a team, but not in fragmented care.

- *"For example, a review of the Health Insurance Act and associated legislative instruments found that there is no MBS-funded pathway for Registered Nurses to conduct attendances for patients (including for the purposes of assessing mental health care needs and instigating a mental health care plan). This would impact their scope of practice in delivering mental health-related care."* P51

RACGP response: The role of the GP has similar limits, with access to different rebates depending on additional training being completed, which was not discussed by the Review. same review might have found similar (smaller) limits for GPs providing mental health care, in different rebates being available depending on additional training being done, despite this being a core and major component of GP work.

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

RACGP response

Rigorous, well-funded clinical trials should be the basis to inform changes in any workforce model.. Independent evaluation of existing and foreshadowed innovations and changes is critical. These should be administered by independent, peer reviewed research organisations.

Considerations for change

- If evidence-based guidelines are available, all professions need to abide by them.
- Workforce models must be supported by health economic evaluation of the use of other health professionals taking on new tasks before implementation of widespread changes. For example,
  - evaluation of nurse-led urgent care clinics in ACT demonstrated very high costs compared to using GP.
  - Local health district run COVID immunisation clinics cost approximately $250 per immunisation, whereas the same service delivered in general practice was approximately 20% of this cost ($50).
- Section 5.1 (p57) suggests establishing an independent national body that would be responsible for providing advice to governments and regulators on how scope of practice for health professionals can continue to meet the community need. Issues Paper 2 states such a body would be responsible for considering how emerging evidence, including in relation to new technology, new roles and new workforce models impact the combined scopes of practice (both overlapping and distinct) of health professionals.

- Research elements that apply include rigorous attention to sampling frame and sample size, with attention to how representative these are of the range of primary care, methods of real-life data collection (must be reasonably time efficient and achievable by a range of consumers and practitioners with different digital and literacy skills), and then interpreted with input by practitioners with expertise in evidence-based interpretation.
- Research skills with clear definitions of objectives and outcomes to be proposed. Where there are questions about the outcomes of proposed changes, for example greater fragmentation of the health system with poorer overall health outcomes for patients, then the objectives of data collection should address these questions. In such cases the full range of quantitative and qualitative research methods should be applied.

Option 6: Harmonised drugs and poisons regulation to support a dynamic health system

RACGP response

This makes sense, so long as there is not a base assumption that the least restrictive regulation is the one to accept nationally. The issue remains that state/territory health ministers can choose to ignore the expertise in medicines scheduling determined by the TGA in favour of lobby groups under the guise of access.

Considerations for change

- "Measuring success" is stated as decreased barriers to scope of practice. Success is better defined as effective, affordable, and safe healthcare.
- Harmonisation of clinical practice by all health professionals with need centralised rather than state-based regulations. However, this may be difficult given state/territory health ministers can choose to not follow national recommendations.

Consultation questions

1. **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?**

- The combined options *may* allow for increased access to healthcare. This could likely be at the expense of quality of healthcare - a major issue for vulnerable populations.
- The RACGP acknowledges the role that our non-doctor colleagues have in improving access and delivering healthcare. However, this needs to be introduced as a response to a manifest community need and in multidisciplinary teams, that include GPs.
- Ahpra must be part of the process as the current Ahpra policies may be unsupportive of expanded scope of practice for health professionals.
- The Review needs to encompass consistency of prescribing rights for GPs with medications such as for ADHD, where there is inconsistency across jurisdictions and an unmet clinical need of patients.

2. **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?**

- The balance required is not about anyone protecting titles, it's about balancing opportunities and risks. This is a specific risk related to particular tasks but also the more general risk of care fragmentation.
- The balance as proposed is skewed away from those with greatest need for access and are most vulnerable.
- There is also a risk to workforce attraction and retention in general practice if GPs become the indemnity 'sponges' for the other professions, as complex or those experiencing and adverse outcome return to their GP.

• Doctors have extensive training in rational prescribing and rational test ordering and dealing with uncertainty. This could be undermined by other professions who do not have the same comprehensive training, where there may be more inclination to order diagnostic tests.
3. Are there specific policy actions related to legislation and regulation you believe should be pursued as part of the above options for reform?
• While the principle of reducing bureaucratic load is a good one, there will need to be specific wording regarding collaboration without being overly restrictive. For example, supervisory models where scope of practice is supported through collaboration or shared care models.
4. Are there implementation options which have not been considered which could progress the policy intent of these options for reform?
No comment.
5. Are there are additional actions relating to leadership and culture which should be considered to encourage decision-makers (National Boards, state and territory governments) to work together in a cooperative way to achieve these policy options?
• The concept of one overarching body needs to provide leadership and policy objectives has merit. There are enough differences between regulating bodies to make the working life of all health professionals cumbersome. • Issues Paper 2 does not integrate how primary care interacts with the rest of health. A significant barrier in implementation of any action is also the split between State and Federal funding and the variable responsibilities across the sector.

3. Theme – Funding and payment policy

RACGP response re: the proposed options 7-8

Option 7: Funding and payment models to incentivise multidisciplinary care teams to work to full scope of practice
RACGP response The RACGP opposes 'cashing in' Workforce Incentive Program and other practice incentive payments. The RACGP supports blended funding/payment models to incentivise multidisciplinary care teams accessing the same patient medical records to work to their full scope of practice. A team working in a general practice is a good example of where this works well and a good starting point to work from. General practice has embedded quality electronic medical records and encrypted electronic communication systems, while private practice allied health professionals/pharmacists are yet to do this on the same scale, despite system availability. These systems are necessary for quality and secure health services. This will require explicit expectations about clinical governance and adequate funding. Adopting the Strengthening Medicare Taskforce Report recommendation, "***Increase investment in the Workforce Incentive Program to support multidisciplinary teams in general practice, improving responsiveness to local need, increasing accountability and empowering each team member to work to their full of scope of practice***".

The RACGP recommends doubling the planned investment in the Workforce Incentive Program – Practice Stream to $890.2 million over five years. This will increase support for collaborative, multidisciplinary care teams to deliver coordinated and continuous care to improve patient outcomes.

Considerations for change

- The principle of 'same job, same pay' for activities being undertaken by a different profession suggests that 'activities' can be defined. A general practice consultation can include multiple 'activities'. If a 'same job, same pay' model was adopted, how would the efficiency and expertise gained by 10+ years of training and 20+ years of experience in clinical reasoning be rewarded? Patients do not present with a diagnosis; they present with a series of symptoms.
- There is no mention of re-igniting a relative values-based approach between services provided by GPs and non-GP practitioners.
- Consider the ability to bill Medicare items for multidisciplinary care outside of the Chronic Disease Management (CDM) plan. Such as inclusions that remunerate enhanced case conferencing and care coordination.
- Enhance the attractiveness of general practice as a career by providing funding for CPD, sick leave, and parental leave.

Other comments

Current planned implementation activities:

- *"Introduce a new blended funding and payment model for primary health care multidisciplinary teams"* p66

  RACGP response: The RACGP opposes the 'cashing out' of current general practice funding to create a speculative, non-evidence-based model of care with no emphasis on the integral role of GPs in the multidisciplinary team. The UK is an example of where pooled funding has failed and exodus of GPs leaving the UK.

- "*Review MBS and other payment rates…"* p66

RACGP response: The proposal for a single payment rate doesn't reflect the reality of delivering clinical care. People rarely present with just one issue and patients often use a service like a vaccination to ask other questions of healthcare staff. There is a risk with this reform that patients will either not seek this additional care if they don't believe they need to, that the service provider is qualified or will request advice that is beyond the scope of the service provider to provide. Or, the service provider will be forced to recall this patient to deal with their additional query in order to be appropriately remunerated.

- "*Design a model of bundled funding for midwifery continuity of care models"* p66

RACGP response: General practice plays a significant role in providing ongoing care to women, children and their families during pregnancy and the early childhood years, along with providing the support, information and referrals to services needed to thrive. GPs provide holistic family centred care pivotal to the child's long-term health and wellbeing. A patient will often consult with their GP in addition to their midwife, therefore there should also be an equivalent allocation of funding for GPs who deliver antenatal care.

Option 8: Direct referral pathways supported by technology

RACGP response

The involvement of GPs for referrals to other clinicians/ pathology/ imaging is an essential component of care coordination. It is unfortunate that the Review presents this diagnostic experience as a barrier.

The requirement for a GP referral has provided a method of gatekeeping to support rational and evidence-based referrals for non-GP specialist care. Removing this may result in:

- increased waiting lists
- rapidly increased or duplicated investigations or intensity of treatment in some cases where treatment at primary care GP level was appropriate. Hospitals in many cases already have strict referral criteria for public services to allow triage.
- Increased health system costs due to do duplicated or unnecessary investigations

To exclude the GP is like having an orchestra without a conductor. Fragmented care is costly, inefficient, ineffective and dangerous. Stott and Davis model of GP consultations describes the opportunity for systematic exploration each time a patient consult. These opportunities are lost without regular GP touchpoint.

Considerations for change

The challenges/risks identified in the Review are correct, but the proposed mitigation of these challenges/risks are unlikely to be effective.

- Evidence-based guidelines are required for referral by health professionals to other disciplines or non-GP specialists.
- It is important to note that existing examples such as referral from optometrist to ophthalmologist sometimes bypasses the GP, thus meaning the GP is not aware of significant health issues.

Other comments

- **Issue 1: Restrictive funding rules limiting direct referrals**

  The Review heard widespread practical examples of where referral to another health professional, or for imaging or pathology, falls within a profession's scope of practice but is limited by MBS funding rules. For example, it is within the competency and training of a physiotherapist to refer a consumer to an orthopaedic surgeon, but the consumer is currently required to access this referral via a GP."

  RACGP response:

  The RACGP accepts the example cited of a physiotherapist referral to an orthopaedic surgeon as appropriate, with a copy provided the GP. There will also be some models where other professionals working in a multidisciplinary team in general practice could also make referrals.

  However, the expression "direct referrals" implies that these are desirable and efficient, and that anything else is undesirable and obstructive.

- **Stakeholder Impacts**

  "…GPs are expected to be less burdened by low-value episodes of care where the consumer seeking a referral has already been instructed to do so by a relevant health professional." P71

  RACGP response: The statement assumes that the GP should follow instructions from another health professional regarding referral, when that referral may in fact be inappropriate and not in line with clinical best practice.

  The RACGP's Red Book 10th ed. separates out screening activities (that should be applied systematically) from a much bigger list of case-finding activities that happen when a generalist sees a patient for any number of reasons. Single task providers won't take ownership of all these case-finding activities.

Consultation questions

1. 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?

- No. The slated $6.1 billion investment over 5 years, is insignificant compared to the annual investment of $77 billion into public hospitals within Australia. A greater investment into more effective primary care would reduce hospital burden and health adversity.
- The RACGP supports the delivery of blended funding on conjunction with a fit for purpose VPR scheme and is supportive of additional funding to support high-quality patient care delivered through general practice. It is important that this is in addition to existing general practice incentives and does not decrease existing incentives that are critical for the sustainability and viability of general practice. This includes flexible approaches to funding general practice multidisciplinary care teams, such as the Workforce Incentive Payment. We support review of MBS and payment rates for general practice to ensure they are commensurate with the delivery of high-quality care. The RACGP has consistently highlighted the need for greater funding for general practice to recognise the expertise and care that they provide and to better support patient outcomes.
- The RACGP is not supportive of pooling the already limited general practice funding to be accessed by a larger group of health professionals. Incentive payments are essential to the delivery of high-quality care in general practice, alongside the fee-for-service funding approach. There is the potential for any changes to incentive payments to significantly undermine the viability of general practices and reduce access to critical care. There is also risk of further devaluing general practice to junior doctors (exacerbate existing pay differences between specialities) which could counter the proposed workforce initiatives.
- The RACGP has strongly advocated for the review of the National Health Reform Agreement (NHRA) to take advantage of opportunities to drive integration and collaboration between primary and secondary health systems and provide maximum return to both health systems. For the NHRA to achieve its goals, significant investment in and prioritisation of general practice will be necessary.
- There is a risk that the policies proposed will fracture the Australian primary care system in a way that is unrecoverable, and Australia will be stuck with a more expensive, less equitable, and less safe system.

2. To what extent do you believe these policy options will help to drive the policy intent of the Review in supporting multidisciplinary care teams to work together to full scope of practice?

- Issues Paper 2 talks about 'more flexible payment models' but then only proposes to expand or cash in things that already exist. The only innovation is proposing to expand these outside of general practice.
- The RACGP is concerned that the proposed policy options could have significant negative ramifications for patients and the health system. There must be no reduction in funding for general practice under any of the proposed models. Fee-for-service must be retained as a core component of the funding for general practice services. We recommend greater investment in general practice MDCT to better support coordinated and comprehensive patient care.
- Without details of the model, it is difficult to foresee the implications and unintended consequences (like fragmentation and siloing of care, increasing healthcare costs and worsening outcomes).

3. Are there implementation options which have not been considered which could progress the policy intent of these options for reform?

- The RACGP recommends doubling the planned investment in the Workforce Incentive Program – Practice Stream to $890.2 million over five years. This will increase support for collaborative, multidisciplinary care teams to deliver coordinated and continuous care to improve patient outcomes.
- Further, this aligns to the Strengthening Medicare Taskforce Report recommendation: *Increase investment in the Workforce Incentive Program to support multidisciplinary teams in general practice, improving responsiveness to local need, increasing accountability and empowering each team member to work to their full of scope of practice.*
- Proactive, continuous, team based coordinated care for complex patients has also been successfully demonstrated by the Department of Veterans Affairs Coordinated Veteran Care (CVC) Program.
  An independent review of the CVC Program identified the benefits of an increased focus on coordination including improved quality of life and social connectedness, as well as avoided hospitalisations. Additionally, CVC participants reported improvements in their ability to navigate the healthcare system and self-manage, alongside related increases in health literacy. The investment in general practice also built capability in the system through enhanced collaboration between GPs and their teams, and other providers.[ii]

[ii] Grosvenor Management Consulting. (2015). Independent Monitoring and Evaluation of the Coordinated Veterans' Care (CVC) Program. Canberra: Australian Government Department of Veterans' Affairs.

Appendix 2

The RACGP has considered the various definitions that were provided by the Review and our feedback on those can be located below.

Amended definitions

The RACGP notes that there has been an amendment to two definitions and makes the following comments about the new definition of Primary health care.

1. Definition of Primary health care

Previous: "Primary health care is health care people seek first in their community, such as GPs, pharmacies and allied health professionals. Generally, this is health care outside of a hospital or non-GP medical specialist."

Current: "Primary health care is the entry level to the health system and as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention to treatment and management of acute and chronic conditions."

RACGP comment: This definition has been improved but is still predominantly transactional in focus and does not adequately address two of the features of 'good' primary care - comprehensive and coordinated care. The four main features of 'good' primary care services include: first contact access for each need; long-term person (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere. Primary care is assessed as 'good' according to how well these four features are fulfilled. (Barbara Starfield, Liyu Shi and James Macinko)

New definitions

The RACGP notes the addition of 16 new definitions in Issues Paper 2 and offers comment on the following:

1. Definition of General practice

"The provision of patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities."

RACGP comment: It is pleasing to see the addition of a general practice definition and in particular acknowledgement of the patient-centred, continuing, comprehensive and coordinated primary care provided to individuals, families and communities.

2. Definition of Multidisciplinary Care Team

"Multi-disciplinary team care in health care is assumed to mean collaborative care, which occurs when multiple health professionals from different professional backgrounds provide comprehensive services by working with each other, and with patients, their families, carers and communities to deliver the highest quality of care across settings."

RACGP comment: The RACGP would add that the team should also be accessing the same patient medical records (different from My Health Record).

3. Definition of para-professional workforce

"Includes health assistants, technicians, care workers, peer support workers."

RACGP comment: RACGP notes that this workforce is already included within the definition of 'health professionals'.

Unchanged definitions

The RACGP notes that there were no amendments between Issues Paper 1 and Issues Paper 2 to the following definitions previously commented on by RACGP."

1. Definition of accreditation

"Refers to a formal process of approval for a program of study or training that provides a person who completes that program or training with the knowledge, skills and professional attributes needed to practice their health profession or undertake that activity."

RACGP comment: This is incorrect. Accreditation certifies that the person or organisation meets a standard that is required to practise or operate (as an organisation) in a specified area of healthcare. Accreditation of general practices does NOT require a program of study or training.

2. Definition of acute care

"Care in which the intent is to perform surgery, diagnostic or therapeutic procedures in the treatment of illness or injury. Management of childbirth is also considered acute care."

RACGP comment: Care of people with chronic disease involves diagnostic procedures, for example monitoring of glycated haemoglobin, lipids and renal function, measurement of blood pressure and fundoscopy among others. 'Acute care' refers to care of people who have an acute condition, that is, one that has arisen or become apparent only recently, such as in the last few minutes, hours or days.

3. Definition of continuity of care

"Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time."

RACGP comment: This is a definition used by the Australian Institute of Health and Welfare and is incomplete. Continuity of care traditionally refers to the therapeutic doctor-patient relationship that develops over time. It is a fundamental element of traditional general practice, increasingly linked with important patient and system effects.

4. Clarification re credentialling

"A formal process used to verify the qualifications and experience of health professionals within a specific health care setting and role, used predominantly in the acute health system."

RACGP comment: Does 'acute health system' translate only to hospitals? GPs provide care of acute problems, such as lacerations or pneumonia and should therefore be considered part of the acute care system'.