Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Unleashing the Potential of our Health Workforce

Scope of Practice Review

Response to Issues Paper 2

Via email to ScopeofPracticeReview@Health.gov.au

Submission by the **Australian Physiotherapy Association**

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The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is for all Australians to have access to quality physiotherapy, when and where required, to optimise health and wellbeing and for the community to recognise the benefit of choosing physiotherapy.

The APA represents more than 32,500 members. We are the peak body representing the interests of Australian physiotherapists and their patients and a national organisation with state and territory branches and specialty subgroups.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

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Table of Contents

1. EXECUTIVE SUMMARY 1

Introduction 1

APA Position 1
Response to Issues Paper 2 1
We are not all the same 1

Conclusion 1
Towards bold, brave reform 1

2. APA'S RESPONSE TO THE CONSULTATION QUESTIONS 2

2.1 Leadership in primary care 2
Q1 What leadership do you consider important to ensure reforms are successfully implemented? 2

2.2 Workforce design, development and planning 3
Q2 To what extend 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? 3
Q3. How should the National Skills Capability Framework and Matrix be implemented to ensure it is well-utilised? 6
Q4. Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care? 7

2.2 Legislation and regulation 8
Q5.To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice? 8
Q6.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? 9
Q7 What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective? 9

2.3 Funding and payment policy 11
Q8. To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice? 11
Q9. What other implementation options should be considered to progress the policy intent of these options for reform? 12
Q.10 What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of the policy options? 13

2.4 Last word 14
Q.11 Are there additional reform options which have not been considered that could progress the intent of this Review? 14
Q.12 Are there additional reform considerations which have not been raised that could progress the intent of this Review? 15

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

1. EXECUTIVE SUMMARY

Introduction

The Australian Physiotherapy Association (APA) welcomes the release of the Scope of Practice Review Issues Paper 2 (Issues Paper 2) and is pleased to provide further feedback on this important process. We congratulate Professor Mark Cormack and his team on producing a solid evidence-based paper to direct some key reform options.

The APA has put forward evidenced reform solutions, including to the Strengthening Medicare Taskforce, to help drive improvements in health system design, address inequities, and improve efficiencies through advancing team-based care. In this submission, we present solutions in utilising our core discipline strengths to drive better, connected, and integrated care that will deliver the four outcomes governments and patients want—high-value care, reduced costs, improved efficiency, and enhanced patient ownership of their own healthcare.

APA Position

Response to Issues Paper 2

Australians deserve access to fully funded physiotherapy that utilises the full scope of physiotherapists' expertise. The current inefficiencies in the healthcare system, particularly in financing care, and the federal-state separation, are major contributors to its complexity. Without comprehensive national reform, patient journeys will continue to be inefficient.

Investments in preventive care and timely access to evidence-based first line treatment can avert the need for more costly medical interventions down the line. The potential for reform exists by leveraging the physiotherapy workforce to support healthier lives and to drive system-level change to advance health, and improve care. These changes are not just possible, they are within our reach.

We are not all the same

We would like to emphasise once again that allied health disciplines are **not all the same**.

The Issues Paper 2 contains concepts that will guide important work in ensuring that the value of each discipline is understood and acknowledged. However, it is important to note that some of the options outlined carry risks, which could potentially lead to the weakening of structures that ensure accountability and oversight in defining their respective scopes. It is essential that these risks are carefully considered and addressed. Our responses to the consultation questions at 2, 5, 6, 7 and 8 provide guidance to uphold integrity to ensure a safe and high-quality health system that provides the most appropriate and best-value care, while keeping patients safe from preventable harm.

Conclusion

Towards bold, brave reform

The APA commends the policy leadership of the Albanese Government in delivering on key commitments in the Strengthening Medicare reform package and having the policy courage to tackle future bold, brave reform to address a failing health system. The options outlined in Issues Paper 2 will bring us closer to ensuring practitioners can work to the full extent of their skills and training. This will enable the Government to guide and execute the urgent, bold changes required to unlock the true potential of the health workforce. Moreover, these changes will pave the way for making integration a reality in our reform efforts.

The APA looks forward to continuing to work together with the Government to support them in their vision to drive transformative change to our healthcare system.

2. APA'S RESPONSE TO THE CONSULTATION QUESTIONS

2.1 Leadership in primary care

Q1 What leadership do you consider important to ensure reforms are successfully implemented?

For example, what is required at the professional, practice, organisation and/or profession level?

APA response:

The Australian Physiotherapy Association (APA) welcomes the release of the Scope of Practice Review Issues Paper 2 (Issues Paper 2) and is pleased to provide further feedback on this important process. We congratulate Professor Mark Cormack and his team on producing a solid evidence-based paper to direct some key reform options.

Healthcare reform requires not only an understanding of the skills held by all health disciplines, but also the commitment to effect change. Reform that supports the patient journey and improves outcomes will not be unanimously popular, as such, there is also need for policy courage among those responsible for initiating change. The Health Minister and his Department must exhibit strong leadership and commitment to evidence-based policy reform. This is crucial for funding changes to Medicare items that limit the scope of physiotherapy, especially in relation to referrals to specialist services and diagnostic procedures. Despite potential resistance from those benefiting from the current system, such reforms are necessary.

Consistent and effective reform hinges on the solid and persistent implementation of the recommendations, education of the effectiveness and benefits, and strong change leadership across the whole healthcare environment. The process of monitoring to inform quality and safety of the implementation needs to be robust, especially with profession-specific changes, depending on the risk involved. Mechanisms must be established to foster coordination among registered (National Registration and Accreditation Scheme) and self-regulated health professions. This requires strong leadership from the Australian Health Practitioner Regulation Agency (Ahpra), in collaboration with Chief Health Officers across sector disciplines. It is crucial to include professional peaks which represent the largest primary care workforces. This includes the APA and representatives from other regulated disciplines, as well as Allied Health Professions Australia (AHPA). Additionally, representation from the self-regulating bodies is necessary. This will empower national Boards to guide and influence work, while also facilitating consultation and collaboration with relevant disciplines including self-regulated professions during design and implementation phases.

Policy courage needs to extend to professional and practice levels. The criteria for those chosen to lead, implement, and initiate these changes should not be limited to possessing a medical degree. It is important for these leaders to have healthcare experience, policy knowledge and public health strategy skills and a solid experience in change management, rather than just expertise in medicine. Senior leaders in these roles may need to broaden their knowledge beyond the role of nurses and medical practitioners. They must fully understand non-medical professions, both regulated and unregulated, their current scope of practice, and recognise their skills and education. This knowledge is essential to understand the optimal patient journey, reduce the barriers, and understand the concept of scope creep and the associated risks.

There needs to be a consistent approach from the leaders and executives of all involved health professions to show a commitment to implement the report's recommendations. Leading from the top will ensure a flow on effect to the clinical interface to ensure effectiveness and quality of the recommended actions of the consultation. Consequently, practicing professional physiotherapy members will need to understand the recommendations and the benefits of implementing them to the profession and to the patient.

2.2 Workforce design, development and planning

Options for reform developed in relation to *workforce design, development and planning* are:

- ***Option one**:* National Skills and Capability Framework and Matrix
- ***Option two**:* Develop primary health care capability
- ***Option three**:* Early career and ongoing professional development includes multiprofessional learning and practice.

Q2 To what extend 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?

Please select only one item

■	**To a great extent**
	Somewhat
	A little
	Not at all

Please provide any additional comments.

APA response:

The Australian Physiotherapy Association (APA) is fully supportive of the three options proposed in Issues Paper 2 which aim at improving health workforce design, development and planning.

The establishment of a National Skills and Capability Framework and Matrix, as proposed in Option One, offers a strategic approach to address the challenges associated with poor recognition of primary care health professional skills and capabilities. Similarly, Option Two, which we fully support, emphasises the importance of enhancing primary care training to equip health professionals with the necessary skills and knowledge to excel in primary care settings. Additionally, Option Three aims to address the challenges faced by early career physiotherapists and promote continuous professional development within primary care settings.

The **combined options** demonstrate potential in addressing the key reform barriers that currently limit high-value care across settings. However, their success is contingent on strong policy leadership. If governments and other funders transition from traditional funding silos to a focus on scope and skills, the proposed options could significantly empower physiotherapists and other allied health professionals. By investing in structured supervision and mentorship programs, facilitating access to education and training opportunities, ensuring national consistency in standards, education programs, competence frameworks and promoting multiprofessional learning, we can enhance the skills, capabilities, and cohesion of primary care teams, ultimately leading to improved patient outcomes and quality of care.

Despite the growth in the size of the primary care, private practice-based physiotherapy, and the broader allied health sector, and the demand for those services, many professions still experience significant challenges finding sufficient clinical placement opportunities. Instead, some professions are still highly reliant on hospital-based services or services in non-primary care settings. Traditional barriers have

restricted access to clinical placements, including the absence of incentives for practices and income replacement for both students and supervisors. While the recent introduction of the Commonwealth Prac Payment for social work is a welcome first step, it needs to be expanded. Other obstacles include restrictions on student usage and solo practices in allied health, and the lack of external student and supervisor supports for primary care placements.

To ensure a sustainable physiotherapy workforce, the profession needs the same training incentives as that of general practitioners (GPs), this includes a funded training pathway. A robust policy for both recruitment and retention planning is crucial to ensure a sustainable pipeline through a training pathway from early career to advanced practice roles. Legislative change is also required to eliminate barriers associated with supervised clinical placements, alongside further policy to fund physiotherapy training placements.

The APA provides further policy depth against each of the options and their related parts.

Option 1.1 | Identifying nationally accepted descriptions of scope of practice

The proposed creation of a skills and capability matrix, outlining the skills and capabilities of each health profession, is a practical solution for enhancing understanding of each discipline's core capabilities. This will be key to improving recognition and utilisation of primary care health professional skills. A national skills and capability framework will also help to highlight the breadth of skill in physiotherapy and facilitate these skills to be maximised by developing clear career pathways and remuneration.

By identifying regulated professions that have already defined their scope at a national level and making this information accessible to other professions, we can enhance understanding and recognition of each other's capabilities. Additionally, efforts to support professions that have yet to define their scope are essential to ensure comprehensive coverage. Acknowledging the scope of activities of the paraprofessional workforce is also critical as their contributions are integral to supporting the regulated primary care team.

However, it will also be essential to have the right controls in place to define scope of clinical practice. Established professions such as physiotherapy already provide standards, fact sheets and consumer information of the scope of practice of a physiotherapist. Potentially, centrally locating the information for patients, referrers, and funders will be important. Statements on scope of practice from non-regulated professions should be overseen to ensure statements are consistent with the National Law and Advertising Guidelines and enforced. We could cite numerous instances where non-regulated groups inappropriately use the term "Specialist", a protected title, which is commonly misused among such professions.

Option 1.2 | Developing a combined skills and capability framework

The creation of a unified framework highlighting shared scope and common capabilities among health professionals is ideal. This framework will serve as a comprehensive guide, providing clarity on the skills and capabilities of health professionals at the entry level of practice. By identifying areas of overlap and commonality, this framework will facilitate better collaboration and utilisation of skills within the primary care team. Medicine and physiotherapy already share a CanMeds model and is a perfect example where cross profession use of a consistent framework forms the basis of alignment in roles such as sports and exercise physiotherapists working in professional sports multi-disciplinary teams.

Option 1.3 |Aligning jurisdictional authorising processes with national scope descriptions

Aligning authorising processes with national scope descriptions is essential for streamlining skill recognition and associated procedures. This alignment will eliminate inconsistencies and redundancies, making workforce planning more efficient and effective. By promoting the framework and matrix, stakeholders can make informed decisions regarding workforce composition, ensuring that primary care teams are tailored to meet community needs effectively. The APA's recent development of a National Framework for Advanced Practice Physiotherapists working in emergency departments is an example of the variation of roles across jurisdictions.

Option 2.1 | Improve the Visibility of Primary Care in Entry-Level Curriculum

The APA fully supports the objective of including primary care-focused learning in entry-level health professional curricula. We believe that integrating experiential learning opportunities and actively involving consumers in curriculum design are essential steps towards achieving this goal. By defining clear primary care learning objectives, facilitating high-quality learning experiences, and aligning with the Inter-professional Education (IPE) competencies framework, we can ensure that graduates are adequately prepared for collaborative practice in primary care settings.

Option 2.2 | Support Supervised Practical Training (SPT)

Providing essential SPT experiences in primary care settings is crucial for developing relevant skills among health professionals. The APA advocates for the establishment of a team of appropriately trained supervisors and the implementation of flexible inter-professional supervision models. We believe that mandating the completion of SPT focused on primary care, along with aligning curricula content with the IPE competencies framework, will enhance the quality and relevance of SPT experiences, and thereby better preparing graduates for practice.

The development of strong partnerships between education providers (universities) and private practices are critical in terms of preparing graduates to enter the workforce. A co-design clinical placement concept where industry and education can work together to develop more effective and earlier exposure to practice and improved clinical placements will enhance the student’s learning in primary care.

However, the lack of funding for clinical placements in primary care, the lack of funding for student support such as student Prac payments, and the impost on private practice severely limit the opportunities for universities and primary care to facilitate learning experiences. A review of the rebate requirements and the ability for student-led treatment of a private patient to be rebated is an urgent item for consultation. Student-led and supervised treatments do not attract rebates from third party funders such as Department of Veteran’s Affairs and Worker’s Compensation bodies. Legislative change is also required to eliminate barriers associated with supervised clinical placements, alongside further policy to fund physiotherapy training placements.

Option 2.3 | Strengthen Interprofessional Education (IPE)

Enhancing IPE is paramount for improving clinician understanding of and skills relevant to collaborative practice. The APA supports the development of a national competencies framework for IPE and actively involving consumers in curriculum design. By promoting the adoption of this framework by education providers and credentialing bodies, we can ensure consistency in IPE implementation and better prepare graduates and clinicians for collaborative primary care practice. The APA has a Physiotherapy Competence Framework that is mutually aligned with medicine based on CanMeds and provides Foundation, Intermediate, Highly Developed and Expert competencies. The accreditation authority for physiotherapy, the Australian Physiotherapy Council, already highlights the need for IPE competencies within all entry level physiotherapy courses, and together with the APA strongly supports inter-professional collaborative practice that delivers patient-centred healthcare.

Option 3.1 | Support early career health professional development

Option 3.1 emphasises the importance of structured supervision and mentorship programs tailored to primary care settings. We advocate for the implementation of such programs to enhance primary care skills and capabilities. By providing guidance and support, these programs will help early career professionals consolidate their skills and navigate the complexities of primary care practice. Additionally, clear processes should be established to identify tasks requiring specific preparation and ensure that supervisors and mentors are adequately trained to provide relevant guidance. The APA has an association-funded mentoring program with volunteer mentors that has program limits available to only 10% of the workforce. Future funding is required to support such a program.

Option 3.2 | Facilitate health professionals to complete post-qualification education and training

The APA recognises the need to facilitate access to post-qualification education and training opportunities. It is essential to support primary care professionals in accessing relevant education and training, particularly in regional and remote areas where access may be limited. The APA has a comprehensive suite of professional development in blended delivery models. Our online learning capability is the largest of any national physiotherapy association worldwide. We propose the development of additional funding to deliver in-service training. Moreover, systems should be established to enable protected time for professionals to complete required education and training, especially for those practicing alone.

Option 3.3 | Facilitate national consistency in post-qualification education and training

Option 3.3 underscores the importance of ensuring national consistency in post-qualification education and training programs. We support processes that align education and training programs with agreed professional standards and competencies, ensuring that graduates develop similar capabilities across professions. Consistent titles for common capabilities, credentials, and qualifications should be employed to facilitate recognition and utilisation of skills by peers and consumers. By promoting consistency, we can enhance the recognition and utilisation of health professional skills. The APA has developed Physiotherapy Career Pathways that support early career clinicians through to Specialist Physiotherapists as awarded by our Australian College of Physiotherapists. The APA advocates for the inclusion of credentialed Specialist Physiotherapists into National Law, and states that regulated health professions with formal competence and education frameworks should be treated equally under the law.

Option 3.4 | Facilitate Multiprofessional Learning (MPL) learning to support health professional development and the primary care team

Option 3.4 highlights the significance of facilitating multiprofessional learning (MPL) to support health professional development and enhance primary care team cohesion. We advocate for the development of education and training packages tailored for MPL in primary care, utilising various teaching methods such as face-to-face, online, and simulated learning. Additionally, processes should be implemented to incentivise physiotherapists to participate in MPL activities, potentially by incorporating a component of mandatory continuing professional development (CPD) to be undertaken with professionals from other disciplines. By promoting MPL, we can foster collaboration among primary care teams and enhance the delivery of patient-centred care. The APA already collaborates with surgeons and urogynaecologists in the development of standards of practice and learning modules.

Q3. How should the National Skills Capability Framework and Matrix be implemented to ensure it is well-utilised?

APA response:

The establishment of a National Skills and Capability Framework and Matrix, as proposed in Option One, presents a strategic approach to address the challenges associated with poor recognition of primary care health professional skills and capabilities.

The establishment of a National Skills and Capability Framework and Matrix is pivotal in enhancing recognition and utilisation of primary care health professional skills.

The development of the Framework and Matrix by cross-disciplinary expert clinical panels, with equitable representation from medical, allied, and non-medical professions and their peak professional bodies, can foster interprofessional understanding. This, in turn, can facilitate government implementation with the backing of professional allied health, nursing, and medical peak bodies.

By identifying scope, developing a comprehensive framework, and aligning authorising processes, stakeholders can optimise workforce planning and shape primary care teams to deliver high-quality

services aligned with community needs. Through collaboration and promotion of the framework, we can foster a more cohesive and efficient primary care ecosystem.

Interdisciplinary comprehension forms the core of trust and collaboration between medical professionals and their allied health counterparts, including non-medical health professionals. A deeper understanding of the scope and skills of allied health professionals among medical practitioners can foster collaborative clinical pathways based on full scope practice. This necessitates enhanced cross-professional collaboration and multiprofessional learning.

A National Skills and Capability Framework in Allied Health, specifically for physiotherapy, should be a comprehensive guide that supports physiotherapists in providing safe, effective, and high-quality care. It should offer a structured approach to physiotherapy workforce development to ensure practical application.

Q4. Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?

APA response:

Developing a National Skills and Capability Framework and Matrix is a key enabler to driving better utilisation of workforce and scope, and ensuring the full workforce is leveraged in reform.

Substantial reform will necessitate leadership from the Commonwealth Health Minister, bolstered by the Department of Health and Aged Care's Primary Care Branch, including a new Chief Allied Health Officer. To effect change, the government and the Department must genuinely commit to transitioning from a sole focus on general practice-led primary care reform to a model that enables authentic multidisciplinary care, where each profession contributes to their full potential.

The formation of clinical leadership and advisory committees or panels will be imperative in making the structure work. The Department has traditionally relied on a group of primary care experts with strong ties to general practice and medical stakeholder groups, such as the Australian Medical College and the Royal College of GPs. These experts, who chair primary care groups and constitute the majority of members, have extensive experience and acknowledge the value of multidisciplinary teams. This in turn leads to unintended policy consequence including the policy advice and guidance being heavily skewed towards GP funding and GP-led models. This is evident in the outcomes of the Medicare Review Taskforce on Primary Care, the work of the Primary Care 10-Year Plan committee, the Strengthening Medicare Taskforce, and ongoing work on Strengthening Medicare reforms such as My Medicare and the Frequent Hospital Users.

2.2 Legislation and regulation

Further three options for reform developed in relation to *workforce design, development and planning*:

- ***Option four:*** Risk-based approach to regulating scope of practice to complement protection of title approach
- ***Option five:*** Independent, evidence-based assessment of innovation and change in health workforce models
- ***Option six:*** Harmonised Drugs and Poisons regulation to support a dynamic health system.

Q5.To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?

Please select only one item

■	**To a great extent**
	Somewhat
	A little
	Not at all

Please provide any additional comments.

APA response:

The policy intent toward a nationally uniform approach to the regulation of health workers is marred by a mix of formal regulation and self-regulation. Different regulatory and funding structures alongside a lack of national planning enables the development of unplanned and self-regulated professions. In allied health, we see a mix of clinical and non-clinical roles, some regulated, others not, with no clear definition of what allied health actually is. Unregulated disciplines operate within a structure that allows them to define their scope without fear of regulatory governance.

The combined options 4, 5, and 6 for reform in relation to legislation and regulation will assist in more effectively deploying the entire health workforce to deliver safe, effective, and cost-effective primary care. It will enhance the use of full scope of practice for many non-medical professions and initiate independent and innovative models of care, such as multidisciplinary teams.

Independent, evidence-informed assessment of innovation will promote new models of care that utilised better workforce planning and utilisation. It will allow that workforce to practice to full scope and within scope. To avoid siloed care and professional competition the process of transferring the use of full scope into practice settings to meet community needs is essential. This will result in multidisciplinary teams that have shared outcomes and collaborative, innovative and efficient patient outcomes incorporating evidence-informed practice.

Harmonising the Drugs and Poisons regulations across the states and territories will support the work currently being undertaken to allow physiotherapists prescribing in Australia. As with other professions, prescribing rights for physiotherapists are varied across jurisdictions creating confusion regarding legal obligations. The APA welcomes a consistent approach to drugs and poisons legislation that allows physiotherapists to legally work with medications as per their scope of practice.

Q6.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?

Please select only one item

	To a great extent
■	**Somewhat**
	A little
	Not at all

Please provide any additional comments.

APA response:

The combined options for reform could lead to significant improvements in the efficiency of our primary care system and ensure equitable access to appropriate care. A strategy based on risk or activity, supported by a uniform method to documenting individual professional scopes of practice, could greatly facilitate more adaptable service provision from a wider range of professions, while maintaining safety. However, documenting scope, regardless of approach, will only support reforms if other enabling changes across legislation and funding guidelines are made.

High-risk and shared scope activities could be developed to sit over the top of separate professional practice standards and guidelines, and then mapped to the professions according to whether they fall under the profession's scope of practice. This would enable the risk activity scope to be more directly regulated under a risk-based approach, rather than indirectly under the protection of the individual profession's specific practice standards.

Concerns around pivoting to a risk-based approach to regulate scope of practice have been reported within the profession. The current legislative mechanism applies a 'named profession' or a 'protected title' approach to regulating scope of practice. This refers to a requirement for a medical professional i.e. GP to instigate, oversee, and approach activities performed by non-medical professionals in the multidisciplinary care team setting. This is referred to as the 'medico-centric' model of primary care.

Currently there are very few risk-based activities that come into a physiotherapist's scope of practice. There may be some shared scope activities but again, they are minimal. Identifying areas of overlapping scope is important for safety and clinical governance monitoring. Moving forward into planning and future legislation and regulation changes for physiotherapy, there will be a need for changes in legislation and regulation in regards to physiotherapists who have completed accredited training modules in prescribing or other activities that may fall under a risk-based approach.

Q7 What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

APA response:

In order to ensure incremental reform, it is important to consider fast tracking the disciplines where professions are within their scope including to enable physiotherapists directly referring to specialists and imaging. By providing a consistent structure for leveraging existing scope and scope expansion, potentially overseen by the proposed independent body, and supported by Ahpra and self-regulating health professions, we could potentially better meet workforce demand.

A supplementary review of the current self-regulation model should be considered a policy priority. This includes exploring ways to enhance standardisation and shared support structures across self-regulating

allied health professions, increase regulatory protections like title protection, and ensure consistent regulatory approaches. Collaboration and shared policy development by self-regulated health professions and Ahpra/Ahpra boards are also crucial. These measures will not only establish a foundation for a more consistent approach but also enhance the quality and safety for patients.

Assigning an existing or new body with the responsibility to conduct economic modelling of the impact of better utilisation of different professions across particular tasks or areas of scope, could help quantify the impact of improved utilisation of different professions across specific tasks or areas of scope.

In 2020, the APA commissioned the Nous Group (Nous) to undertake a landmark analysis of the value of 11 physiotherapy interventions[1]. By doing so, we have built a robust picture of our high-level impacts and the value this provides to the healthcare sector. The study found that treatments by physiotherapists deliver both health and economic benefits. Interventions are clinically effective and deliver net economic benefits, with quality of life improvements exceeding treatment costs. In 2023, the APA commissioned further economic modelling from Nous to measure the economic impact of physiotherapists' direct referrals to orthopaedic surgeons and for some diagnostic imaging. Analysis[2] from Nous shows that Medicare funded direct referrals from physiotherapists could bring a total of $162.7 million savings for patients and the healthcare system. Indeed, Nous has identified that patients could save $115.3 million in out-of-pocket and travel costs, and a further $47.4 million would be saved from the health system in avoided Medicare costs.

The options for reform must always recognise specific professional independence and autonomy so that the public can maintain trust in any relevant healthcare professional. A clear road map for implementation and accountability is necessary. The Minister for Health must lead the proposal to assure Boards and State authorities of their commitment to the proposed reforms and changes. While there may be financial benefits to reforms, the focus needs to be on measuring improved access and care. Enhanced cooperation, efficiency, transparency of findings, clear actionable points to healthcare workers, and a strong focus on good corporate governance processes are key.

2.3 Funding and payment policy

Two options for reform have been developed relating to the theme of *funding and payment policy*:

- ***Option seven:*** Funding and payment models incentivise multidisciplinary care teams working to full scope of practice
- ***Option eight:*** Direct referral pathways supported by technology.

Q8. To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

Please select only one item

■	**To a great extent**
	Somewhat
	A little
	Not at all

Please provide any additional comments.

APA response:

If properly implemented, the proposed options will achieve significant reform and improvement of the access issues experienced by many primary health patients. Greater focus also needs to be on the improved utilisation of skills through advanced scope of practice roles, particularly Advanced Practice Physiotherapist, to address current and future need. In addition, reform must tackle the existing system complexities including removing barriers to integrated care. It will be important to ensure that alongside legislative and funding reform, and technological enablement, multidisciplinary clinical committees direct care guidelines. These guidelines should support safe, high-quality care, and foster understanding of different health professions' roles in clinical pathways.

There is a need to review the current Health Insurance Act 1973 that restricts scope of practice of non-medical professionals, such as physiotherapists and the requirement for them to be 'overseen and approved' to perform in-scope activities. Physiotherapists are able to refer directly to specialists and certain imaging that is currently within a practitioner's scope of practice, but there is no MBS item number so there is no rebate from the MBS for this referral. Direct referral capability is currently in a physiotherapist's scope of practice but not utilised effectively nor efficiently or economically for the patient.

Physiotherapists already have core training at an undergraduate level to assess patients for appropriate referrals to imaging and to orthopaedic surgeons. This is further enhanced at a titled and specialist level of physiotherapy education. This is not fragmented care, it is streamlined and efficient and will not cost more money to the health system with a 'flood of referrals' as shown by the Nous report mentioned above, and no further change in regulation or legislation is needed to enable direct referrals for physiotherapy.

Both options will need to be examined and implemented separately as they address two distinct issues for reform.

Option 7 | Funding and payment models that incentivise multidisciplinary care teams working to full scope.

Allied health funding remains unequal to its medical counterparts within the MBS system. There remains a focus for models of care to be doctor-led. There are many examples of nurse-led and allied health models of care that are very successful and utilise the expert skills of the non-medical professionals to provide evidence-based, safe, and cost effective care to patients and families.

Option 8 | Direct referral pathways supported by technology.

Reflecting back on the initial purpose of the Scope of Practice Review, there is a need to recognise that the government wants to utilise 'current' scope practice capabilities and skills that can be instigated immediately to improve primary care interactions and interventions. The current skills and scope of physiotherapists, as a regulated profession, come under NRAS and therefore have regulated quality and safety mechanisms. The physiotherapy profession does not need further micro-credentialing processes to enable the use of direct referrals supported by technology and participation in multidisciplinary care teams.

The APA recognises the argument that physiotherapists are one of the only non-medical professionals that currently have the expertise, scope of practice, and diagnostic and clinical reasoning skills to enable the use of direct referrals to appropriate imaging and orthopaedic surgeons. Anecdotally, most GPs and orthopaedic surgeons who have had discussions with the APA support and agree that physiotherapists already have the diagnostic skills and scope to participate in direct referrals and show inter-professional trust in the capabilities and decision making skills of physiotherapists.

As a profession, the APA does not support the concept of direct referrals being opened widely to a broad allied health cohort, especially the non-regulated and self-regulated professions. The physiotherapy profession is not, in any way, devaluing the diagnostic and assessment skills of the broader medical community, it recognises the level of these skills in the physiotherapists practicing in Australia and their current scope and capabilities in assessing the needs of the primary care patient for further assessment and care.

A new MBS item that rebates patients for physiotherapy-led direct referrals is an essential part of this reform. Once in place, further education internally by the profession will be developed to inform and educate the members about this reform intent. Physiotherapists do not need any further education or micro-credentialing to perform these referrals as it is currently within their scope of practice and capabilities. This is a limited MBS funding policy issue and not so much linked to a regulatory barrier.

In looking at reforming the referrals system and associated MBS items, and to ensure Australians can quickly benefit from the reform, it is our position that priority should be given to referrals that are already in scope of the discipline and do not require further training or micro-credentialing. The current MBS rule (note GN.6.16) has provisions for optometrists to refer patients to ophthalmologists and midwives to obstetricians. These can be described as logical 'combinations' within a typical care journey with strong scope alignment. Physiotherapists referring to orthopaedic surgeons should logically be next. There are other pathways that are similarly in scope of specific disciplines that should be prioritised such as psychologist referrals to psychiatrists.

Q9. What other implementation options should be considered to progress the policy intent of these options for reform?

APA response:

Flexible and consistent funding for multidisciplinary team care models is needed to improve quality of care and must compliment the already entrenched fee-for-service model. Well-executed and well-funded team-based care can offer high-quality care resulting in better health outcomes, and allow all involved professions to work to full scope and to work together.

The Workforce Incentive Program (WIP) was established to support team-based care in rural locations by financially incentivising GPs to engage a range of health professionals, including allied health. As these reforms are GP-centric, there are limitations to the extent that allied health professions can support their communities. There is the potential to reform the WIP and allow Primary Health Networks (PHN) to commission multidisciplinary teams to meet the needs of their community, this would allow utilisation of the already existing healthcare workforce with the respective PHN.

Addressing the barriers to implementing funding for multidisciplinary care teams is key. For these teams to be effective and independent, the right digital health technology is essential. Such technology enables the sharing and reviewing of medical records, facilitates case conferences, and ensures high-quality care. There is an urgent need for different payment models to replace the outdated single practitioner, fee-for-service model that currently impedes reform progress. This includes a comprehensive review and redesign of the Chronic Disease Management (CDMs) program, which currently imposes arbitrary annual limits that are not aligned with evidence-informed practice and the reality of actual practice.

Q.10 What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of the policy options?

APA response:

While general practice is central to many aspects of primary care, it is not the only component. A cultural shift is necessary within the Commonwealth in setting the primary care policy agenda. This shift will necessitate robust roles for allied health and nursing chiefs and their respective teams. The formation of clinical working groups to advise on reforms and guide policy development is crucial. It is important that these committees maintain a balanced representation of professions and do not merely mimic existing GP-led models. Instead, they should include fair representation and leadership from specialist medical and allied health professionals. This approach will foster clinical discussions and leadership that prioritise outcomes and mutual understanding over professional boundaries.

2.4 Last word

Q.11 Are there additional reform options which have not been considered that could progress the intent of this Review?

APA response:

Aside from direct referral, the reform options in Issues Paper 2 mainly focus on potential future initiatives and reforms, without providing specific examples or options for short-term trials to demonstrate their effectiveness and support testing. The APA proposes that existing Strengthening Medicare initiatives, such as Urgent Care Clinics and the Frequent Hospital Users program, could be restructured to focus on multidisciplinary models involving doctors, allied health professionals, and nurses. These models could incorporate many of the key reform options outlined in this paper.

There is also a need to ensure there remains a core focus on the quick reform wins that leverage the most suitable disciplines for immediate change, benefiting patients. This includes publicly-funded First Contact Physiotherapy (FCP) practitioners who can effectively manage musculoskeletal (MSK) conditions, thereby reducing the burden on GPs in primary care.

The key opportunities are provided below.

Priority 1 | Physiotherapy in Medicare Urgent Care Clinics

Improve access to care at the primary and acute interface through the inclusion of physiotherapists in the staffing and funding models in Medicare Urgent Care Clinics.

Physiotherapists working to their full scope of practice is a solution to both the GP and ED crisis. Physiotherapy is key to ensuring continuity of care in primary and acute care because they can alleviate GP workloads, and divert people with urgent but non-life-threatening conditions from EDs. Ensuring physiotherapists are utilised in Medicare Urgent Care Clinics (UCC), where a significant proportion of the likely patient load in these clinics will be MSK conditions such as sprains, strains and spinal pain—conditions best managed by physiotherapists, will be key to their success.

Priority 2 | Physiotherapy-led non-operative pathways

Physiotherapy-led non-operative pathways to reduce surgical wait-list times, reduce the need for specialist reviews and reduce surgical intervention rates.

Non-operative pathways that are led by physiotherapists work efficiently across many MSK conditions, as well as medical and surgical pathways such as urinary incontinence treatment, to prevent costly surgical interventions. Primary review and treatment by skilled physiotherapists can help to avoid surgical interventions, avoid hospitalisation, reduce length of stay in hospital, shorten surgical waitlists and improve patient satisfaction. The cost-benefit of avoiding surgical procedures and specialist reviews is significant. Service solutions include physiotherapy-led Orthopaedic Screening Clinics for patients with chronic MSK conditions who do not need immediate surgery and who will benefit from well-coordinated multidisciplinary management.

Priority 3 | Leverage proven advanced practice models used in secondary and tertiary care

Expand advanced practice physiotherapist roles in primary and community healthcare to increase non-surgical evidenced-based primary management and preventive strategies to help satisfy unmet patient need across a range of areas.

Physiotherapists work across the healthcare system providing many opportunities for physiotherapists to lead care, including in leveraging advanced practice physiotherapy hospital-based models. Advanced practice physiotherapists already work in advanced-level clinical roles to improve service efficiency, pathways and outcomes in many clinical specialties in hospital care, such as in Emergency, Orthopaedics,

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Neurosurgery, Rheumatology, Urology/Gynaecology, Neurology and ENT services. Advanced practice physiotherapists use high levels of clinical expertise and experience to assess and coordinate care for specific cohorts of patients, often with complex presentations. These services have been demonstrated to be safe, clinically effective, and highly cost effective in comparison to usual care models.[3] [4] [5]

Specialist physiotherapy services and advanced practice physiotherapists are an under-recognised value-added step between the GP and medical specialist. Increased utilisation of the skills and competencies of these clinicians can positively contribute to the health of Australians who suffer the burden of complex/persistent MSK pain complaints.[6]

There is significant opportunity to leverage and utilise this highly-skilled clinical workforce in the primary care setting. For example, models of care are already being tested in primary care which streamline care pathways using the expertise of advanced/ specialist physiotherapists to improve the primary care management of patients with MSK conditions.[7]

Q.12 Are there additional reform considerations which have not been raised that could progress the intent of this Review?

APA response:

There is a significant body of evidence in relation to the benefit of allowing physiotherapists to work as close as possible to the top of their scope. The Review should also look to the evidence base as detailed in the MBS Review Taskforce on Primary Care. This was a significant body of work which considered how MBS items could be better aligned with contemporary clinical evidence and practice, to improve health outcomes.

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[1] Nous. (2020). Economic value of physiotherapy.

[2] Unpublished at the time of writing. Available upon request.

[3] Lafrance, S., Vincent, R., Demont, A., Charron, M., Desmeules, F. (2023). Advanced practice physiotherapists can diagnose and triage patients with musculoskeletal disorders while providing effective care: a systematic review. Journal of Physiotherapy, 69(4), 220-31.

[4] Comans, Raymer, O'Leary, Smith, Scuffham. (2014). Cost effectiveness of a physiotherapist led service for orthopaedic outpatients. Journal of health Services Research and Policy, 19(4), 216-223.

[5] Samsson, K.S., Bernhardsson, S., Larsson, M.E. (2016). Perceived quality of physiotherapist-led orthopaedic triage compared with standard practice in primary care: a randomised controlled trial. BMC Musculoskelet Disord., 17, 257.

[6] Beales, D., Mitchell, T., Holthouse, D. (2021). Stepped care for musculoskeletal pain is ineffective: a model for utilisation of specialist physiotherapists in primary healthcare management. Australian Journal of Primary Health, 27, 431-436.

[7] Rebbeck T, Evans K, Ferreira P, et al (2021). Implementation of a novel stratified PAthway of CarE for common musculoskeletal (MSK) conditions in primary care: protocol for a multicentre pragmatic randomised controlled trial (the PACE MSK trial). BMJ Open, 11, e057705.