Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Unleashing the Potential of our Health Workforce

Scope of Practice Review

Response to Draft Final Report

Via email to ScopeofPracticeReview@Health.gov.au

Submission by the **Australian Physiotherapy Association**

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Acknowledgement of Traditional Owners

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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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

1. EXECUTIVE SUMMARY

Introduction

The Australian Physiotherapy Association (APA) welcomes the opportunity to provide input to this third and final phase of the review. We congratulate Professor Mark Cormack and his team on producing a solid, evidence-based Draft Final of the Unleashing the Potential of our Health Workforce (Scope of Practice Review) Report that provides a considered approach to the key challenges to the delivery of primary health care in Australia.

The APA also commends the policy leadership of the Albanese Government and Health Minister Mark Butler 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. Realising the Government's four-point vision for strengthening Medicare would see the greatest reform of Medicare since the scheme began.

APA position

Response to the Draft Final Report

The Draft Final Report provides important reform directions that will ensure that the value of each discipline is understood and acknowledged, encompassing the right safeguards 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.

In driving the required system-level change to advance health and improve care, the APA is particularly pleased to see that the potential of the physiotherapy workforce has been acknowledged and prioritised for **direct referral pathway** reform and in-scope for priority changes to MBS payment rules. Recommendation 14 and its accompanying criteria will ensure the measure is contained to the right disciplines, including physiotherapy referral to orthopaedic surgeon, while ensuring the treating team, including the patient's general practitioner (GP), is notified.

Physiotherapists are among the few 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. While we were disappointed not to see digital imaging referral included in the recommendations, Recommendation 14 will address significant barriers that currently limit high-value care across settings.

In strengthening **multidisciplinary care**, recommendations 12 and 13 aim to strengthen collaborative practice but remain reliant on the existing structures, rather than empowering regulated, medically aligned front line disciplines to lead. While we recognise that an incremental approach to reform is necessary for significant change, expanding the leadership roles of disciplines such as physiotherapy, nursing and psychology is where the reform needs to occur. Additionally, recommendation 13, which directs bundled payments for **maternity services**, entrenches the current approach, once again neglecting early intervention, prevention and ongoing post-birth pelvic health and musculoskeletal care.

It is also important that the Review also directs the required reform within **Private Health Insurance** as the Government holds the policy levers. This relates to recommendations 7 and 12. While addressing the barriers for allied health training within the MBS (recommendation 7) is welcomed, it is essential to extend this to other funding mechanisms and schemes. There are multiple payment options for allied health in primary care including private health insurance and state and territory compensable schemes. To ensure physiotherapy students receive quality primary care education and training experiences, the billing rules for all funding schemes need to be amended.

Conclusion

Making integration a reform reality

Healthcare reform requires not only an understanding of the skills held by all health disciplines, but also the commitment to effect change. Reform hinges on the solid and persistent implementation of the recommendations. It is clear that 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 options outlined in Professor Cormack's Draft Final Report, if implemented, will bring us closer to ensuring practitioners can work to the full extent of their skills and training. The draft final report provides a number of positive reform options and offers a clear road map for implementation towards a redesigned primary care sector as the core of an effective, modern health system. This will enable governments 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 enabling modern models of health delivery. This Review has achieved its overarching objective to provide recommendations to address scope of practice issues that contribute to a misalignment between the present-day reality for patients and health professionals and the new policy vision for Australia's primary health care system.

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 Introductory Chapters

Q1 Do you have a comment on the Introductory Chapters?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections. For example, what is required at the professional, practice, organisation and/or profession level?*

APA response:

The *Introductory Chapters* are clear and set up the paper well, although could be enhanced by setting out the reform failures briefly in terms of enabling scope to clarify the objective closer to the front.

The *Background* could be improved by a brief mention of the comprehensive consultation undertaken with the review. The *Primary care* section adequately explains the context including the need to explain that the reform extends beyond just general practice to encompass all first contact practitioners. For completeness, the regulated and non-regulated point should be encompassed here. *The journey* section outlines a comprehensive and inclusive consultation process. *The case for change* encompasses the necessary policy depth but strengthening the 'why' and the required dependencies – legislation, regulation and funding reforms – to enable practitioners to work to full scope and deliver care as part of integrated, multidisciplinary primary care teams needs more emphasis.

2.2 Theme A: Workforce design, development, education and planning

Q2 Do you have a comment on the proposals for reform or recommendations outlined under Theme A?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections.*

APA response:

A1: National Skills and Capability Framework and Matrix

The APA supports the proposals for reform against Theme A1 to develop a National Skills and Capability Framework and Matrix.

The Matrix offers a strategic approach to address the challenges associated with poor recognition of primary care health professional skills and capabilities. However, if it is to support an activity-based approach to legislation and regulation, as intended, more attention to ensuring the right controls are in place to define scope of clinical practice will be essential. This seems underdone in the policy commentary although picked up in the directions that underpin **Recommendation 1**.

The four directions underpinning Recommendation 1, from 1.1 to 1.4, set the required parameters to ensuring the National Skills and Capability Framework have equal representation of all the professions (medical, allied and non-medical professions) and reflect the individual's full scope of practice, code of

conduct and the National Law. There are risks in not defining scope and overlapping scope can result in poor quality and clinical standards.

The Matrix must reflect university curriculum, research, career pathways, accredited CPD and quality standards to avoid ill-defined description of capabilities and competencies. Defining the role of the individual practitioner in the patient pathway and within the multidisciplinary team as part of the matrix is essential for optimal quality patient care.

A2: Strengthen the capability of the primary health care workforce

The APA supports, in principle, the proposals for reform against Theme A2 to strengthen the capability of the primary health care workforce.

The Primary Health Care Workforce Development Program and related streams would address the current workforce reform barriers. The reform direction and related **Recommendations 2 to 7** hold significant promise to strengthening both training and teaching capacity. The focus on addressing inconsistencies impacting on workforce capability, including those related to equity in access to training and teaching supports, is welcomed. Past reforms have only occurred for one discipline, general practice. The directions aim to leverage and extend these programs to the rest of the primary health care workforce, particularly in rural and remote areas.

A successful Primary Healthcare Workforce Development program (page 70) will require barriers to student billing beyond the MBS to be addressed.

Although addressing the barriers for allied health training within the MBS is welcomed (**Recommendation 7**), there is a need to ensure this is extended to other funding mechanisms and schemes. There are multiple payment options for allied health in primary care including private health insurance and state and territory compensable schemes. To ensure physiotherapy students receive quality primary care education and training experiences, the billing rules for all funding schemes need to be amended.

2.3 Theme B: Legislation and regulation

Q3 Do you have a comment on the proposals for reform or recommendations outlined under Theme B?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections.*

APA response:

The APA supports, in principle, the two reform proposals for reform against Theme B and provides further policy commentary to these below.

B1: Equitable approach to regulating scope of practice

The APA supports, in principle, the reform directions to Initiate a more balanced and consistent approach to regulating scope of practice (**Recommendations 8, 9 and 10**).

Further clarity is needed regarding which legislation/s require reform.

Although the APA provides in principle support to Recommendations 8-10, further detail is required within section B1 of the report to clarify which legislation/s the suggested reforms align. For example, the references to Drugs and Poisons Acts, Radiation Safety Acts and Mental Health Acts, suggest the reforms

outlined in this section pertain to state and territory legislation and regulatory instruments, or those unrelated to the National Registration and Accreditation Scheme (NRAS). However, the options provided from page 84 onwards suggest amendments to the National Law.

The APA acknowledges the legislative barriers are outlined in the summary on page 77, however there is a lack of policy depth in the supporting narrative, including a lack of clarity around which jurisdictions or laws are under the reform lens.

The APA supports, in principle, activity based-regulation (Recommendation 8).

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.

Harmonisation of existing legislation can support health professionals working to their full scope of practice.

The lack of consistency in state and territory legislation, particularly within Drugs and Poisons Acts, has the potential to limit the scope of physiotherapists. As such, the APA provides in principle support to **Recommendation 9**. We would particularly support the development of a shared glossary as suggested on page 88.

Strengthening regulation for professions sitting outside the NRAS is required.

The APA provides in principle support to **Recommendation 10** as a means of strengthening regulation for those outside of the NRAS in order to support public safety.

The three potential options for reform offered (page 84), Option A to C, from *Focused* to *Expansive* reform, each hold merit. We note these would be subject to an Impact Analysis in assessing their appropriateness and the related rapid impact analysis of the three reform options (10.1).

While we acknowledge Options B and C would support an expanded scope of practice for certain self-regulated professions, we have concerns such professions might gain an advantage due to a continued lack of required NRAS oversight and full adherence to the National Law. Further, the need for state and territory legislation regarding particular health related activates, such as Drugs and Poisons Acts, suggests such activities hold some form of public risk. Therefore, we would question why such activities are being undertaken by professions who have been deemed to not meet a sufficient risk threshold to be regulated under the NRAS.

B2: Equitable approach to health workforce innovation, access and productivity

The APA supports, in principle, the establishment of an Independent Mechanism (Mechanism) to provide evidence-based advice and recommendations to Health Ministers' Meeting (HMM) (**Recommendation 11**).

The Mechanism is sensible reform, and with adequate funding and appropriate administration, will address a key gap in health workforce planning. Further, it will enable proven models of care to be developed and scaled to support community need by allowing many non-medical professionals to work to a full scope of practice.

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.

The APA supports the principle of effective governance which would see independent representation but would stipulate that the required disciplines, those of the full health workforce, be represented (page 99).

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2.4 Theme C: Funding and payment policy

Q4 Do you have a comment on the proposals for reform or recommendations outlined under Theme C?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections.*

APA response:

The APA supports, in principle, the two reform proposals for reform against Theme C and provides further policy commentary to these below.

C1: Risk adjusted blended payment funding model

The APA supports, in principle, the reform directions to enable a new blended payment model aligned with the Strengthening Medicare reform, facilitating multidisciplinary care teams (MDT) to work to their full scope of practice (**Recommendation 12**).

The shift of the payment model over time towards a funding ratio with a more significant blended component, reflecting the size and growth of the population with complex care needs, aiming for a 60:40 split over time through a staged repurposing of existing payments, is fully supported. However, the reform will be limited if we continue to prioritise a gatekeeping model of care that is ineffective and financially unsustainable and rely on reform measures currently underway which have already proven ineffective.

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 non-medical professionals to provide evidence-based, safe, and cost effective care to patients and families. Despite a strong evidence base, it is clear that in establishing access in these proposed reform measures, those eligible as fund-holders will predominantly be GP practices (12.1) or large corporate practices given the parameters listed against 12.2, and again in prioritising the initial sources as set at 12.3.

The list of in-scope payments to incorporate into risk-adjusted blended payments on page 104 requires attention.

Measures are needed to improve access to essential care, reduce out-of-pocket costs and, most importantly, reduce low-value care. This is reliant on flexible and consistent funding for multidisciplinary team care models to improve quality of care. 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.

We urge caution in relying on the current reform underway in the Effectiveness Review of General Practice Incentives, particularly concerning the Workforce Incentive Program (WIP).

In its most recent consultation process and supplied draft, the WIP detail has failed to direct the necessary reform. The required adjustment to the WIP to direct packaged incentives to ensure that it targets the incentive to the health workforce gap, rather than funnelling them through general practice—which affects thin markets—has been overlooked.

The WIP's ill-conceived design prioritises GP practices and having to house the service within the practice, which is not the right approach to enable multidisciplinary care. **This requires addressing and a reframe**

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of the related recommendation in the draft report to enable professions to work to their full scope and collaborate effectively, without being dependent on being housed within a GP practice.

In unlocking access to care, more emphasis on leveraging the Primary Health Networks (PHN), rather than flawed incentives like the WIP, is needed to strengthen multidisciplinary team care. There is the potential to reform the WIP and allow PHNs 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.

Additionally, a key missed opportunity lies in increasing and **expanding case conferencing**, including elevating the role and status of physiotherapy and psychology in these conferences.

In the reform mix for the blended payments review, the paragraph on page 105 is key, yet lost in the policy discussion.

Private Health Insurance (PHI) is a key enabler for allied health, both in terms of scope and in driving MDT care. Emphasising the importance of PHI is vital to drive reform beyond a fee-for-service system. This approach is essential for fostering integrated care models that can deliver high-value, patient-centred outcomes. Ensuring that PHI supports allied health services will help unlock the full potential of the health workforce and facilitate sustainable, system-level changes.

It is important that the Review also directs the required reform within PHI as the Government holds the policy levers. This emphasis in the Report should extend to a point to the need to reducing the legislative barriers to preventative models to ensure the sustainability of PHI for all Australians. This would encompass preventative measures like non-operative preventative pathways for osteoarthritis of the hip and knee as a key example. Physiotherapy-led non-operative pathways reduce surgical wait-list times, reduce the need for specialist reviews and reduce surgical intervention rates.

Recommendations 12.4 to 12.7 are supported in principle, however, the policy depth in the Report is not necessarily sufficient to comment comprehensively. In the sub-recommendation 12.5, in implementing alternative enrolment models to ensure access to blended payment in underserviced areas, the regulated first contact professions, including physiotherapy, should be prioritised. A staged approach commencing in rural and remote regions (12.7) is supported.

Bundled payment for maternity services (C1)

The APA supports, in principle, the reform directions to introduce a bundled payment for maternity care, inclusive of midwifery continuity of care models, for combined care provided in primary health care and in public hospital settings (**Recommendation 13**).

The APA supports the critical role of midwives in collaborative multidisciplinary maternity care yet seeks to understand how this recommendation enables the broader MDT team. The recommendation entrenches the current approach, once again neglecting early intervention, prevention, and ongoing post-birth pelvic health and musculoskeletal care. This direction maintains and broadens traditional midwifery model of maternity care, but it is unclear how the proposed midwifery continuity of care model will address existing service gaps.

There is insufficient focus on the requirement to address unmet need across the pre-and post-natal care continuum. In particular, the diagnosis and treatment of pelvic, musculoskeletal, and mobility symptoms and conditions related to birth trauma and early parenthood have been overlooked. Reliance on existing funding mechanisms has the potential to maintain the status quo of fragmented, inconsistent care. The required service triggers for evidence-based multidisciplinary care referrals are not covered.

There is also potential for a collaborative model of care build in PHI, however there remain issues of equity and affordability in maternity services coverage. Collaborative multidisciplinary pre-and post-natal primary health care must have GPs, midwives, obstetricians, gynaecologists, midwives, physiotherapists and maternal and child health nurses as its centre, with access to other services as required.

C2: Direct referral pathways

The APA supports, in principle, the proposals for reform against Theme C2 to enable direct referral pathways supported by technology.

In driving the required system-level change to advance health and improve care, the APA is particularly pleased to see that the potential of the physiotherapy workforce has been acknowledged and prioritised for **direct referral pathway** reform and in-scope for priority change to MBS payment rules. Recommendation 14 and its accompanying criteria will ensure the measure is contained to the right disciplines, including physiotherapy referral to orthopaedic surgeon, while ensuring the treating team, including the patient's GP, is notified.

Physiotherapists are among the few 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. While we were disappointed not to see digital imaging referral included in the recommendations, **Recommendation 14** will address significant barriers that currently limit high-value care across settings.

2.5 Theme D: Enablers

Q5 Do you have a comment on the proposals for reform or recommendations outlined under Theme D?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections.*

APA response:

The APA supports, in principle, the directions and recommendations under Theme D necessary to enable the reform (**Recommendations 15 to 22**).

Healthcare reform requires not only an understanding of the skills held by all health disciplines, but also the commitment to effect change. Reform hinges on the solid and persistent implementation of the recommendations. It is clear that 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.

Proposals for reform:

D1: Culture and Leadership

The APA fully supports **Recommendation 15**.

The reforms outlined in this report have the potential to support significant improvements to the provision of healthcare in Australia. For this to occur there is a need for all stakeholders to support and drive the changes that are required.

D2: Program governance, change management and evaluation

Communications and training strategies should be developed collaboratively.

The APA supports, in principle, the recommendations related to implementation of the outlined reforms (**Recommendations 16 and 17**). Consumer input is essential, as outlined in Recommendation 17, as is input from the entire health workforce. It is important that all health professions have the opportunity to contribute to communications and training strategies by detailing their scope and role in primary care.

Under *Place-based tailoring of program governance* (page 123) the APA suggests highlighting the importance of this element in the provision of health services for Aboriginal and Torres Strait Islander peoples as well as those from other culturally and linguistically diverse populations.

D3: Cultural Safety

A culturally safe workforce is critical to ensuring First Nations Australians receive high quality healthcare that meets the needs of their communities. As such, the APA supports **Recommendations 18 and 19** which aim to embed cultural safety in primary health care delivery.

D4: Clinical governance

Utilising PHNs to support primary care providers in strengthening clinical governance and risk management makes sense as they are best placed to understand the unique requirements of their communities. As outlined in the report (page 129), PHN engagement with allied health is inconsistent, therefore the APA provides in principle support to **Recommendation 20** to allow PHNs to fully support all primary care providers in their remit.

The APA provides in principle support for the requirement for primary care providers to participate in an applicable Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation program (**Recommendation 21**). However, it should be noted that the provision of allied health care can require accreditation against multiple programs. Adherence to multiple programs is expensive and the APA suggests that accreditation against the ACSQHC National Safety and Quality Primary and Community Healthcare provides reciprocal accreditation against other schemes.

D5: Rural and remote focus

The report underplays the rural emphasis and needs to address the most significant challenges for critical access. A lack of adequate investments to strengthen health systems and policy inaction have led to increased rural disadvantage. Past rural health reform efforts have focused on solutions within medical models and a sole discipline focus on financing care.

New funding models to increase rebated allied health services, including targeted skills initiatives, are needed. Rural reform that continues to direct funding through general practice is failing these communities. Workforce solutions that focus on facilitating wider scopes of practice and place a greater emphasis on multidisciplinary care will address the rural workforce crisis.

Despite strong evidence for integrated care models to advance allied health services, successive health budgets have delivered minimal change from conventional primary care. New practice viability funded supports that consider geographic, demographic, workforce, and training variables are needed. Earlier consultations in the Scope of Practice Review emphasised the need to prioritise rural implementation, including through pilots, but this seems to have been dropped in the last iteration.

D6: Digital health

Digital health is essential to the future of Australia’s health care system. We need to strengthen our digital health capabilities and test value-creating solutions in enabling reform in primary health care. This is captured well in the direct referral discussion but lacking in other parts and more emphasis throughout is

required. The key requirement to modernise My Health Record to enable full participation by all professionals and accelerate interoperability with practice management systems needs to be emphasised.

D7: The business model of primary care and General Practice

An integrated, comprehensive primary healthcare system that delivers best care, needs the skills of the entire health workforce. Multidisciplinary care teams can provide the most comprehensive care possible, at the right place and time for each patient.

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 and their respective teams.

A GP working in isolation is not a team. We need to move beyond the idea that general practice is the only setting where primary care takes place. This is stopping us from implementing the real reform measures that will enable the best care, at the right place and time for each patient.

Physiotherapists predominantly operate under a private business model, as do most allied health professions, and the viability of practices across all health disciplines should also be a focus. There is an imbalance, particularly in the drivers for multidisciplinary care, with a continued emphasis on funnelling incentives through general practice.

D8: Primary care system integration and support through Primary Health Networks

The APA supports **Recommendation 22** in enabling PHNs to expand their capacity for integration and practice support, particularly in relation to allied health.

2.6 Implementation Roadmap

Q6 Do you have a comment on the Implementation Roadmap?

- *Seeking your comment on factual errors or inconsistencies within the report, and how these might be addressed.*
- *Please include relevant page numbers, paragraphs or sections.*

APA response:

General comments:

The Draft Final Report offers positive reform options and a clear roadmap for a modern primary care sector. These changes will enable practitioners to fully utilise their skills and integrate modern health delivery models. The Review has successfully provided recommendations to align current practices with the new policy vision for Australia's primary health care system. The high-level roadmap presented is comprehensive in outlining the key recommendations and implementation steps for reform to a five-year period.