AHHA response to the Unleashing the Potential of Our Workforce – Scope of Practice Review

Submission

16 October 2023

OUR VISION

A for a healthy Australia supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective
Accessible
Equitable
Sustainable
Outcomes focused

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide input into the Unleashing the Potential of our Workforce – Scope of Practice Review. Our submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public healthcare, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to healthcare of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, Primary Health Networks, community, and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

BENEFITS OF EXPANDED SCOPE OF PRACTICE

Who can benefit from health professionals working to their full scope of practice?
How can these groups benefit? Please provide references and links to any other literature or other evidence.

Health professionals working to their full scope of practice must be driven with the overarching objective of improving the health outcomes of people and communities for the resources to achieve those improved outcomes (i.e. value-based health care).

Consumers, communities, healthcare professionals and providers can all benefit from health professionals working to their full scope of practice only if scope of practice reform is pursued for the purpose of enabling person-centred models of care delivered by multidisciplinary teams, not driven by vested interests that may not align.

Recognising the inherent interdependency and increasing complexity of health care, the potential to work to full scope (and achieve the associated benefits) will be reliant on the work context and practices that enable individual professionals to work within teams. Therefore, recommendations to 'unleash the potential of our workforce' must not be informed by health professions in silos, but with consideration of the skill mix within teams.

The following is an extract from the AHHA Blueprint supplement, *Enabling person-centred, team-based care*[1]. References are included within that publication.

> 'A person's health and well-being is dependent on the interplay of complex relationships between biological, lifestyle, socioeconomic, societal and environmental factors (AIHW 2016). Enjoying the highest attainable standard of health is a human right, but the conditions for doing so are well known to be inequitably distributed (AIHW 2016). Practically recognising and responding to these factors and conditions in health care needs to be a priority (Farre & Rapley 2017).
>
> Health care is inherently interdependent and increasingly complex (Rosen et al. 2018). Medical knowledge is expanding exponentially, with the volume estimated to be doubling every 50 years in 1950, to doubling every 73 days in 2020 (Densen 2011). Staying current across the breadth of information is an increasing challenge for any individual.
>
> With aging populations and an increasing prevalence of multimorbidity, a shift from a single disease focus is needed (Harrison et al. 2016) and priority setting is critical (Harris et al. 2013). The value from embedding non-clinical support in the provision of health care (such as social prescribing and mental health support) is well-recognised (e.g., CHF 2019; Black Dog Institute 2019) and an important preventive health strategy.
>
> The need for integrated, team-based models of care has been promoted for decades (Farre & Rapley 2017), yet the system is still facing challenges in operationalising such models.'

This blueprint supplement highlights the benefits of teams for:

- Person-centred care:
  - Care providers work together with a shared focus centred on a person's needs and with collective ownership of the goals to be achieved. Continuity in team-based care arrangements may be facilitated over time through better recognition of and valuing the coordination and integration role (RACGP 2020), e.g., the general practice in patient-centred medical home (PCMH) models or opportunities for care coordinator or navigator roles.
- Building capacity for a region or community:
  - The way in which people access health care in rural and remote areas differs from those in metropolitan areas, with smaller facilities, less infrastructure and the need to provide a broader range of services to a more widely distributed population;
- The providers:
  - Improving clinician well-being and satisfaction and reducing burnout;
- The system;
  - Improving timeliness and access to care, reduced costs of service delivery and operational efficiencies.

RISKS AND CHALLENGES

What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?
Please give examples of your own experience.
Please give any evidence (literature references and links) you are aware of that supports your views.

AHHA requests that the reviewers consider the risks associated with practitioners working to their full scope or expanded scope of practice in a manner that differentiates the risks when individual health professionals are working in isolation or in professional silos, from the risks when individual health professionals are working in supportive and integrated team environments, where:

- care pathways are clear within the local context;
- clinical governance is effectively designed, implemented and monitored; and
- outcomes are monitored and communicated in a timely manner.

REAL LIFE EXAMPLES

Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care? Please give examples, and any evidence (literature references and links) you have to support your example.

Team-based care occurs when care providers work together with a shared focus centred on a person's needs and with collective ownership of the goals to be achieved. Effective teams enable each member of the team to work to their full scope, as they are supported to effectively address problems that arise that are outside their scope.

The following is an extract from the AHHA Blueprint supplement, *Enabling person-centred, team-based care*[1]. References are included within that publication.

> 'Teams may encompass members from both clinical and nonclinical disciplines, across various settings, including acute and primary care, as well as settings broader than just health care. Providers may be from the public, private or not-for-profit sectors, functioning under one organisational umbrella or drawn from a range of organisations. Distinctly, however, teams see themselves, and are seen by others, as an intact social entity (Cohen & Bailey 1997). In the context of patient care, they are identifiable and cohesive in their relationship with the patient, their family and carers, who themselves are critical, active members of the team.'

Reference should also be made to the policy briefs published by the European Observatory on Health Systems and Policies in 2022, titled:

- *Skill mix innovation, effectiveness and implementation: improving primary and chronic care*[2]
- *How can skill-mix innovations support the implementation of integrated care for people with chronic conditions and multimorbidity?*[3]

The following are examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care:

MARATHON HEALTH INTEGRATED TEAM CARE

Marathon Health's national Integrated Team Care (ITC) program supports First Nations people who live with chronic diseases and have complex healthcare needs[4]. ITC is delivered on behalf of the Murrumbidgee PHN - working closely with Aboriginal Medical Services (AMS), allied health practitioners, medical specialists, public and private GPs, and the Murrumbidgee Local Health District.

The program takes a team-based approach to care planning, with 10 Care Coordinators (40% who identify as First Nations) whose role is to work with participants to:

- Coordinate care and services
- Improve and support self-management and health literacy
- Ensure the participant is at the centre of a team-based and empowering approach to their care planning, with their GP and other relevant members of the broader health care team.

The team is also working with more than 40 GP and AMS clinics across the Murrumbidgee to build the capacity of staff to deliver culturally safe and appropriate services, in a bid to reduce unnecessary hospital admissions. Last financial year, they supported 297 clients and delivered 8,600 occasions of service through ITC.

RIGHT CARE = BETTER HEALTH PROGRAM

The RC=BH Program has demonstrated an innovative approach to care coordination within a general practice setting[5]. It has engaged nurse care coordinators embedded to work as part of a general practice team in a collaborative relationship with a wide variety of services in the acute and community sectors. The value of care coordination in avoiding hospital admissions and improving patient's health and wellbeing is an integral benefit of the program.

HEALTH JUSTICE PARTNERSHIPS

The following is an extract from the Health Justice Australia website[6]:

'Health justice partnerships provide integrated health and legal care for individual clients. They build the capability of health and legal practitioners and services to provide more holistic person-centred care. They also advocate for change which improves the health and wellbeing of communities.'

'Health justice partnerships address the legal problems in people's lives that are affecting their health and wellbeing. Left unaddressed, legal problems lead to stress, create barriers to health and wellbeing, and hold people in cycles of disadvantage and struggle.

Health justice partnerships address the link between family violence and poor health; between a neglected mouldy public housing estate and respiratory problems; between debt, fines and increased anxiety.'

ALLIED HEALTH RURAL GENERALIST PATHWAY (AHRGP)

The Allied Health Rural Generalist Pathway (AHRCP) is a workforce development strategy aimed at supporting rural and remote communities through team-based healthcare performed by a fit-for-purpose, sustainable, generalist workforce in the allied health professions (AHPs)[7].

Informing pathway development is the range of allied health workforce challenges identified in rural and remote communities, including; Primary care funding models that limit the variability of allied health providers, Limited Continuing Professional Development (CPD) opportunities that meet the diverse learning needs of rural generalists AHPs, and the small professional workforces (in particular teams of sole clinicians, or few practitioners of the same profession) resulting in:

- Limited profession-specific support, peer learning and supervision opportunities. Low or no leave cover for training or recreation leave.
- Limited clinical governance and allied health leadership.
- Limited career progression and succession planning.

The Pathway therefore integrates; Rural generalist allied health service delivery strategies and service development priorities that reflect local health needs, Rural generalist training positions with embedded training supports and expectations, and Formal (university) rural generalist education programs tailored for rural generalist scopes of each profession (including advance practice and/or extended scope, including skill sharing tasks between professions).

AGED CARE ASSESSMENT TEAM (ACAT) IN PARTNERSHIP WITH LOCAL ABORIGINAL MEDICAL SERVICE (AMS) GURRINY YEALAMUCKA

The Aged Care Assessment Team (ACAT) within the Cairns and Hinterland Health and Hospital Service (HHS) identified that despite having a high proportion of ageing community members with complex needs, there was a very small number of referrals to ACAT from the Aboriginal community of Yarrabah[8].

In response to the identified needs and in collaboration with community, ACAT and Gurriny co-designed a more flexible model of care that addressed the unmet needs and barriers to clients accessing an assessment and services after assessment. The model involved a team-based approach developed via a formal partnership with the local Aboriginal Medical Service (AMS) Gurriny Yealamucka and the development of a close working with relationship with the community service provider Mutkin Aged and Community Care in Yarrabah.

In 2021, this resulted in tripling ACAT referral numbers, over doubling the number of aged care assessments completed and facilitating access to aged care services for the older population of Yarrabah.

MODELS OF CARE FOR IMPROVED ORAL HEALTH OUTCOMES

Innovation to improve oral health outcomes through optimising scopes of practice within teams has been demonstrated in various research, including:

- Value-based approaches driven by Dental Health Services Victoria[9]
- Developing and deploying mid level dental providers[10]

FACILITATING BEST PRACTICE

What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.
What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.
Enabling health practitioners to work to their full scope of practice must be driven from a system perspective, rather than by individual professions. It is important that the intended aims of changes to skill mix are clear, driven by population needs and implemented as part of appropriate workforce planning and deployment, with attention to role expectations, professional boundaries, legal issues, and active management of change[11].

A review of regulatory approaches from the US, Canada, Australia and the UK has identified five principle-based leading practices for regulating scope of practice[12].

In Australia, regulation is applied at multiple levels, which varies across jurisdictions, to control scopes of practice. However, scopes are also influenced by professional bodies, service agreements, delegation and supervision models, board certification requirements, and funding arrangements. Developed in silos with varying underlying intent, together these can result in unnecessarily restricting work practices and scopes for models of care that may otherwise improve outcomes with the resources available.

In this published review of regulatory approaches, Australia has been identified as having leading practices in the regulatory principles of Definition and Collaboration. However, Australia needs to focus its attention on the regulatory principles of:

- Flexibility, e.g. looking to Canada, where umbrella frameworks offer regulatory flexibility and loosen the restrictiveness of scopes of practice
- Accountability, e.g. looking to the UK, where transparent and publicly accountable risk-based processes exist with a separate oversight body
- Efficiency, to optimise coherence, coordination and communication while maintaining focus on public safety.

Governments should pursue:

1. Establishing an **independent oversight and advisory body**.
   Cross-sector and whole-of-government cooperation is necessary. As such, this body should have top-level leadership and support that includes finance, treasury, education and health sectors[13].
   The body should be consistent with other health technology assessment approaches, being independent, outcomes-focused and evidence-based. The body should be able to advise on both investment and disinvestment decisions. In establishing the independent body, findings from the current HTA Review[14] will likely provide guidance, e.g., around:
   - Identifying person and community-relevant outcomes
   - Evidence and evaluation
   - Transparency in decision-making and communication

- Ensuring investment in those scopes that will provide substantial improvement in health outcomes of people and communities, equitably and sustainably
- International work sharing
- Adaptability and flexibility in approaches to allow for future advances
- Implications of decisions on funding models.

2. **Joint workforce planning** at a local level to match skill-mix approaches with population needs.
   This is expanded on in the AHHA Blueprint supplement, *Enabling person-centred, team-based care*[1]. References are included within that publication.

3. A **clinical governance framework** for team-based care that can be adapted by teams to reflect the local context and meet the needs of patients and the local community, while assuring quality and safety.
   This is expanded on in the AHHA Blueprint supplement, *Enabling person-centred, team-based care*[1]. References are included within that publication.

4. Systematic use of **clinical and social indicators, measures of self-care capability and activity, and patient-reported measures** to support patient-centredness in team-based care. Investment in primary care data infrastructure and linkage across the hospital, social and other sectors is needed to enable real-time, shared decision-making.
   This is expanded on in the AHHA Blueprint supplement, *Enabling person-centred, team-based care*[1]. References are included within that publication.

5. **Funding contracts that support flexibility** in how different parts of the workforce are used in the design of place-based models of care, where outcomes are defined and appropriate clinical governance is prioritised for monitoring, rather than specific roles and inputs for the workforce prescribed.

'Unleashing the potential of workforce' will also require the workforce trained through the vocational education and training (VET) sector to be considered in an integrated manner. The VET workforce includes allied health assistants, Aboriginal health workers, oral health workforce and peer workers, to name a few.

This workforce is particularly crucial in supporting innovative models of care where there are workforce shortages, such as in rural and remote areas. With effective place-based clinical governance arrangements, this workforce can support e.g., relational care, culturally appropriate care, virtual care and continuity of care. Assuring safe and high quality care will require this workforce to be embedded and supported within a team that involves a broad range of health practitioners but who may not all be locally-based.

Locally relevant and appropriate VET pathways, including education pathways that extend into higher education, will be crucial to examine in developing this workforce. Education and training policies and funding models must be examined from a place-based perspective to ensure equity in access to quality health care.

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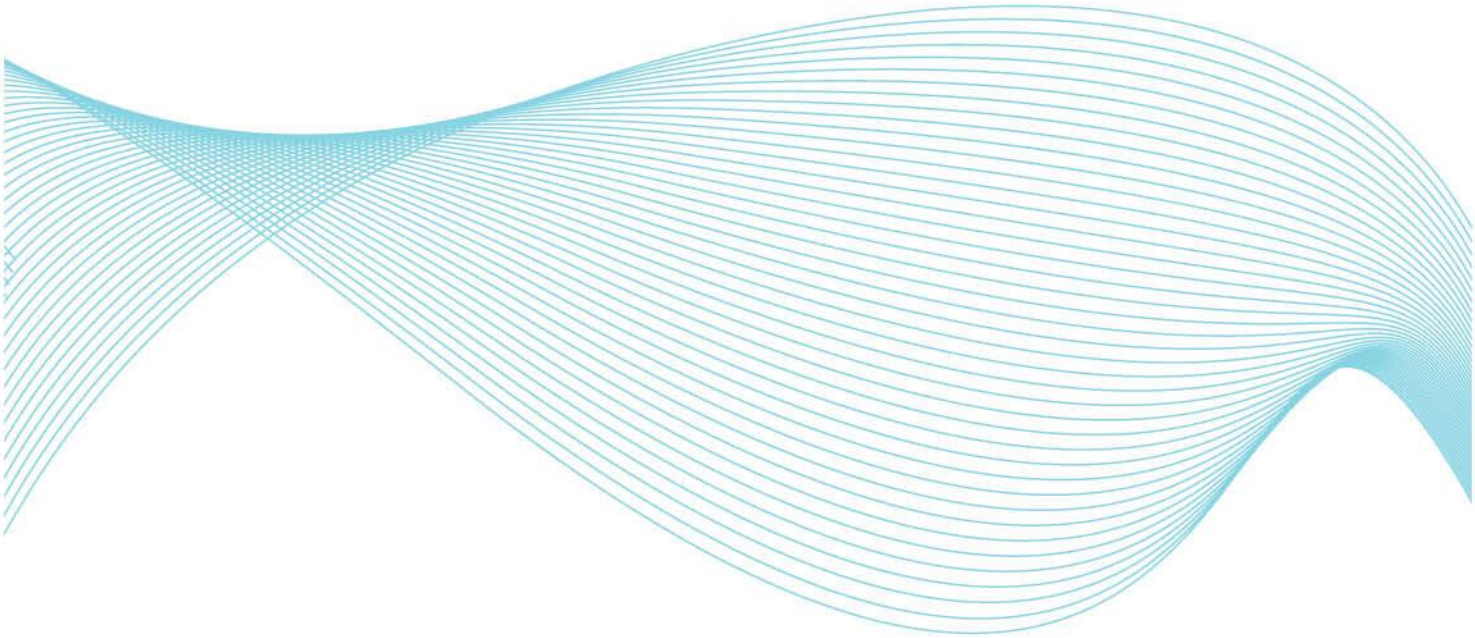

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the voice of public healthcare

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