AHHA Response to Issues Paper 2 –

Scope of Practice Review

Submission

26 May 2024

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

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Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide feedback on Issues Paper 2 – Unleashing the Potential of our Health Workforce (Scope of Practice) Review.

This submission builds on consultation undertaken with health system leaders in developing the 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 AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care 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 on-for-profit, hospitals, PHNs, community and primary health care services.

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

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and their communities for the resources to achieve these outcomes, with consideration of their full care pathway.

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 the siloed views will not achieve the system Australians deserve.

AHHA response

Issues Paper 2 of the Unleashing the Potential of our Health Workforce (Scope of Practice) Review identifies rural and remote areas as 'an appropriate setting for localisation and applications of reform options, and a key priority for implementation'. It goes on to propose a 'rural and remote 'launch pad' for specific reform to be explored' (page 30). Accordingly, this submission focuses on how scope of practice reform can be implemented in rural and remote areas, recognising the unique challenges of providing health care in this context, but also the opportunity for innovation that shifts the focus from activity to outcomes and that can inform national policy more broadly.

In this submission we propose governments systematically connect national policy levers with the proposed 'launch pad' sites, with a requirement to be responsive in implementing scope of practice reform to drive better health and wellbeing outcomes in rural and remote primary health care. To do this, government must ensure the approach is:

1. Focused on health and wellbeing outcomes.
2. Supports local areas to spend budgets flexibly.
3. Enables place-based workforce development.
4. Provides more effective accountability and a learning system for local areas.
5. A whole-of-government priority.

We have not attempted to record further examples of the problems faced at a local level, as many have been shared with the Review Team already. Rather, we propose a model for implementation that brings together expertise and decision-makers across the system. However, we are available to share specific exemplars as needed.

The approach to the implementation plan must be focused on enabling local solutions, removing barriers faced at a local level in a timely manner through a supportive and responsive national framework.

Our members are committed to improving primary healthcare access and better health and wellbeing outcomes in rural and remote communities. Together, we welcome the opportunity to workshop with the Scope of Practice Review Team, and government, implementation of scope of practice reform.

Background

For decades, primary health care in rural and remote areas has been identified as a major health priority for both national and state/territory governments.

Almost 20 years ago it was reported[1] that rural health policies over the previous decade had been driven by the need to reduce health inequalities between metropolitan and rural Australia. Policies had concentrated on addressing workforce issues, targeting the medical workforce in particular. Building on this, a systematic review of primary health care delivery models in rural and remote Australia was undertaken in 2006 (see Box 1) to inform the systematic development of sustainable comprehensive Primary Health Care service models appropriate to rural and remote Australia.

This systematic review described five broad categories of health service models, highlighting there is no 'one coat fits all' model, but that the diseconomies of scale could be addressed by aggregating a critical population mass (whether that be a discrete population in a town or a dispersed population across a region).

Box 1. 2006 systematic review of primary health care delivery models in rural and remote Australia[1]

The review identified that the development of primary health care services should be guided by addressing three key environmental enablers:

- Supportive policy,
- Commonwealth/State relations, and
- Community readiness;

and five essential service requirements:

1. Workforce organisation and supply,
2. Finding,
3. Governance, management and leadership,
4. Linkages, and
5. Infrastructure.

Since 2006, there has continued to be various initiatives implemented and research undertaken, with a National Strategic Framework for Rural and Remote Health[2] being developed in 2011 through collaboration between the Commonwealth and State, and the Northern Territory governments by the Rural Health Standing Committee.

The Framework similarly recognises the unique characteristics and challenges in planning, design, funding and delivery of quality, contemporary health care, and proposes five goals (see Box 2).

Box 2. 2011 National Strategic Framework for Rural and Remote Health[2]

Five goals are identified:

1. Improved access to appropriate and comprehensive health care
2. Effective, appropriate and sustainable health care service delivery
3. An appropriate, skilled and well-supported health workforce
4. Collaborative health service planning and policy development
5. Strong leadership, governance, transparency and accountability.

There have been many other similar papers and proposals identifying the same broad enablers and requirements for primary health care services in rural and remote Australia, as well as a multitude of funding opportunities that address different enablers and requirements, but in isolation of the others.

The issue

Workforce recruitment and retention challenges continue to challenge health care delivery across rural and remote Australia. Out of necessity, innovative multidisciplinary and virtual care models are piloted, but their systemic adoption is limited by the range of factors identified in the literature over the past decades.

Scope of practice is one component of this, and the related impeding factors have been identified in Issues Paper 1 and 2 of this review – legislation and regulation, funding and payment policy, workforce design, development and planning, technology, and importantly for the consideration of any implementation of reforms in rural and remote areas, leadership, culture and clinical governance.

Despite continued recognition of the systemic issues that require attention to improve health outcomes for rural and remote Australians, initiatives and investments occur without the *environmental enablers* adequately supporting *service requirements* (as described in the 2006 systematic review described above).

Implementation through rural and remote 'launchpads'

AHHA commends the Scope of practice review team for explicitly identifying a need to define an implementation plan.

AHHA supports the proposal for implementation through rural and remote 'launch pads', and proposes that to genuinely make investments effective and sustainable, governments must systematically connect national policy levers with the proposed 'launch pad' sites, with a requirement to be responsive in implementing scope of practice reform to drive better health and wellbeing outcomes in rural and remote primary health care. The approach must:

1. Be focused on health and wellbeing outcomes.
2. Support local areas to spend budgets flexibly.
3. Enable place-based workforce development.
4. Provide more effective accountability and a learning system for local areas.
5. Be a whole-of-government priority.

1. Focused on health and wellbeing outcomes

The Treasury must recognise implementation through rural and remote 'launch pads' as an opportunity to embed 'Measuring what matters' in these communities.

Having established Australia's first national wellbeing framework, The Treasury must recognise implementation through rural and remote 'launch pads' as an opportunity to embed 'Measuring what

matters' in these communities. In introducing initiatives identified in the Scope of Practice Review, the 'launch pad' sites can use the national wellbeing framework for understanding, measuring and improving on what matters to Australians in these communities.

Using the Framework holistically in these communities can reorient the current focus that comes through siloed, contractual requirements on the workforce inputs to rural and remote primary health care, and instead provide a holistic focus on the outcomes to be achieved.

Globally, health systems are shifting towards value-based health care (VBHC) as a framework for bringing stakeholders together around a shared goal of improving health outcomes, sustainably and equitably. Our national wellbeing framework provides the policy intent that supports operationalisation of VBHC in the primary care context through the initiatives identified in the Scope of Practice Review.

2. Supportive of local areas to spend budgets flexibly

Place-based approaches to health care recognise the variation in need between communities and ensure existing assets are leveraged in models of care to strengthen the system overall. Funding should be applied flexibly to incentivise outcomes, not inputs and activity.

As noted by the Review Team, current funding streams can be a barrier to sustainable care models that would better meet people's needs.

The flexibility to redistribute Commonwealth funds allocated for services within hospitals to other sectors has restrictions. These restrictions can apply even when evidence supports the shift. For example, moving from the hospital to models of care outside of the hospital or to care models that leverage technological advances. Innovation, when it has occurred, has typically occurred as a result of the states redistributing their own funding contributions, rather than innovation being incentivised by the Commonwealth. However, the ability for States to sustain these innovations is challenged if the model results in a reduced funding contribution from the Commonwealth.

Outside of Agreements, the Commonwealth provides funding for primary care through a range of mechanisms, including the Medicare Benefits Schedule (MBS), general practice incentive payments, the Community Pharmacy Agreement, Primary Health Network commissioning, direct funding of initiatives and Partnership Agreements with states and territories, as well as through the National Disability Insurance Scheme (NDIS) and aged care funding. States, in addition to contributing to hospital funding, also fund primary and community care through a range of programs.

Local service providers may be recipients of multiple funding streams, particularly those providing services to priority populations. These services then use this mixed funding to develop a service offering that not only meets the contractual obligations of each funding stream, but meets community need and provides a coherent employment model for their workforce. The viability of the service offering as a whole is often then dependent on maintaining all of the funding streams – both exacerbating the focus on activity rather than outcomes, but also potentially restricting the delivery of all services.

This can be a particular concern where there are thin or no markets, as in rural and remote Australia. While these have been the subject of many reviews, debates about thin markets use terminology

variably and there is limited evidence to guide policy.[3] What we observe though, in Australia, is governments applying their stewardship of such markets in silos (between health, aged care and disability sectors; between levels of government; and between programs within each level of government).

Instead, we need collaborative, place-based approaches to longer-term planning, with pooled funding to invest in and evaluate healthcare models focused on outcomes, not activity.

3. Enabling place-based workforce development

Workforce-related policy levers and associated funding streams need to be applied flexibly at the local level to provide the support for learners and associated employment opportunities along a career pathway.

A strong and effective health workforce is essential to a functioning health system. However, our members and stakeholders continue to identify workforce challenges as one of the most critical issues limiting universal access to health care. The challenges are diverse, and not unique to Australia:[4] workforce shortages, skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, a skewed gender distribution, limited availability of health workforce data, persist, often within an ageing workforce.

There are many policy levers that shape the health workforce; these areas were explored more fully in the AHHA submission[5] to the mid-term review of the National Health Reform Agreement. And workforce-related policy levers that are applied for national or state/territory consistency are often restrictive, inflexible and unsupportive of rural and remote contexts.

A place-based approach would support investments in developing people in rural and remote communities that are not siloed into health, aged care and disability sectors. Rather, a range of connected initiatives would be supported along the workforce pipeline that, for example:

- Develop pathways for the local untapped and underutilised workforce ('grow your own', e.g. migrant and refugee women, women returning to work, high school)
- Embed roles in the community that support connection and navigation of health care
- Ensure desirable employment opportunities (e.g. single employer models)
- Provide the practical support necessary for students to engage in learning along the career pathways (e.g. 'earn while you learn', flexible workplace learning, financial support through placements).

Policy levers and associated funding streams (both at a national and state/territory level) would need to be flexibly applied at the local level, responsive to the workforce and health needs of the community.

4. Developed with more effective accountability and a learning system for local areas

Learning health systems will bring together stakeholders to provide a systematic approach to iterative, data-driven improvement in outcomes achieved through primary health care.

Learning health systems have been identified globally as 'the next stage in quality improvement' and 'what is required to find a sustainable way out of the current crisis' for health systems. They are defined as 'a systematic approach to iterative, data-driven improvement', where a learning community is 'formed around a common ambition of improving services and outcomes'.[6]

While there are many examples of learning health systems, all with variation in their approaches, four common areas for achieving progress have been identified: [7]

- Learning from data
- Harnessing technology
- Nurturing learning communities
- Implementing improvements to services.

These areas were explored more fully in the AHHA submission[8] to the mid-term review of the National Health Reform Agreement.

Reorienting the focus to outcomes in rural and remote primary health care will need collaborative partnerships to be formed between communities, service providers, policy makers and funders. These must be underpinned by trust and transparency and can be used to address concerns relating to risk and governance.

5. A whole-of-government priority

There must be whole-of-government commitment to connect grassroots innovation in rural and remote communities with the necessary policy levers in a timely manner.

Decades of research and reviews (as described above) have identified that improving primary health care in rural and remote locations requires *service level* innovation to be supported by *environmental enablers*. There is currently no holistic approach to achieve this.

There must be whole-of-government commitment to connect grassroots innovation with the necessary policy levers in a timely manner. This starts with national leadership in the form of commitment from National Cabinet. However, it also requires pre-emptive recognition from the diverse departments and independent agencies and entities, at a national and state/territory level, to be responsive in addressing barriers identified by 'launch pad' sites and leveraging their particular expertise in supporting the shift towards outcomes.

While each 'launch pad' site will have unique challenges and barriers that need a response in order to meet their community's particular needs, there are also shared opportunities for enablement (Table 1).

Table 1. Examples of opportunities for responsive national policy support for rural and remote launch pads
**Note: it is not being suggested that engagement across all of these entities will be needed for progressing every 'launch pads', but all would need to be committed to the facilitating the intent*

Treasury	**National wellbeing framework** Having established Australia's first national wellbeing framework, The Treasury can embed use of 'Measuring what matters' in these 'launch pad' sites for understanding, measuring and improving on what matters to Australians in these communities. The Framework can reorient the current focus on the inputs to rural and remote primary health care from a range of sources, and instead provide a focus on the outcomes to be achieved.
Treasury and the Department of Social Services (leads)	**Tackling entrenched disadvantage** The government's approach to target entrenched disadvantage involves place-based partnerships to see the codesigned solutions that address communities needs and aspirations. These principles to deliver outcomes in community also underpin what is needed for the health and wellbeing of rural and remote communities.
Australian Centre for Evaluation	**Evaluation and performance monitoring** Established to put evaluation evidence at the heart of policy design and decision-making, it can support evaluation of complex policy issues. Value may be gained from the Centre facilitating a shared understanding between communities, service providers, policy makers and funders about, for example, risk-based evaluation and performance monitoring focused on outcomes.
Australian Commission on Safety and Quality in Health Care	**Accreditation standards** Accreditation standards are an important part of assuring quality and safety. However, in rural and remote areas it is often the one service providing care across health, mental health, aged and disability care. The administrative burden associated with demonstrating compliance across multiple standards can be prohibitive to accessible, effective and efficient service provision. Mapping of standards and streamlining accreditation processes for services in rural and remote areas is needed.
Independent Health and Aged Care Pricing Authority	**Funding models** Consistency in funding models in rural and remote areas is particularly critical to ensure they are incentivising a holistic approach to health and wellbeing. IHACPA has significant expertise in developing and transitioning to new costing methodologies, including consideration of the data elements for enabling pricing and funding reconciliation, considering outliers and variation, accounting for risk, minimising undue burden, and the potential medium- and long-term impacts of pricing models. With explicit functions in relation to public hospitals and residential aged care services, advice in relation to health care and at home aged care services can be provided on request.

HumanAbility, the Jobs and Skills Council for this sector	VET workforce In rural and remote areas, the workforce that is vocationally educated and trained is of critical importance, and not just for supporting continuity at a local level for care models with transient health professionals. The health sector provides significant employment opportunities, an important determinant of health, and there are untapped opportunities to improve the workforce pipeline from high school through to health professions. With long lead times in the workforce pipeline, the VET sector enablers must be prioritised by governments as part of the implementation plan
Department of Health and Aged Care	Outcomes-based contracts and agreements Outcomes-based contracts will be critical in underpinning implementation to: - provide more flexibility in how funding is spent - provide longer contract terms, bringing financial and operational certainty Collaborative partnerships underpinned by trust and transparency will be needed between governments, service providers and stakeholders in communities and can be used to address concerns relating to risk and governance.

State/territory-based departments and agencies would also need to be committed and responsive in providing equivalent policy support.

Conclusion

With rural and remote areas identified as 'an appropriate setting for localisation and application of reform options, and a key priority for implementation', this Government has the opportunity to connect a range of strategic initiatives they are leading to drive primary healthcare access and improved health and wellbeing outcomes for rural and remote communities.

AHHA welcomes the opportunity to work with the Review Team to refine and implement this outcomes-focused, value-based approach that systematically connects national policy levers with the proposed 'launch pad' sites, in implementing scope of practice reform.

[1] https://nceph.anu.edu.au/research/projects/systematic-review-primary-health-care-delivery-models-rural-and-remote-australia
[2] https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf
[3] https://www.themandarin.com.au/wp-content/uploads/2019/12/Market-capacity-framework-CSI.pdf
[4] World Health Organization. (2016). Global strategy on human resources for health: Workforce 2030. https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf
[5] https://ahha.asn.au/wp-content/uploads/2023/11/ahha_submission_to_the_mid-term_review_of_the_nhra.pdf
[6] Hardie, T., Horton, T., Thornton-Lee, N., et al. (2022). Developing learning health systems in the UK: Priorities for action. The Health Foundation and Health Data Research UK. https://doi.org./10.37829/HF-2022-I06
[7] Hardie, T., Horton, T., Thornton-Lee, N., et al. (2022). Developing learning health systems in the UK: Priorities for action. The Health Foundation and Health Data Research UK. https://doi.org./10.37829/HF-2022-I06
[8] https://ahha.asn.au/wp-content/uploads/2023/11/ahha_submission_to_the_mid-term_review_of_the_nhra.pdf