Scope of Practice Review

Submission to the Department of Health and Aged Care

November 2023

ABOUT NACCHO

NACCHO is the national peak body representing 145 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 145 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Acknowledgements

NACCHO welcomes the opportunity to provide a submission to Unleashing the Potential of our Health Workforce – Scope of practice review.

NACCHO supports the submissions to this consultation made by its Members and Affiliates.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term:

Priority Reform Area 1 – Formal partnerships and shared decision-making
This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector
This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions
This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making
This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

Review of Closing the Gap

In its recent review of the National Agreement on Closing the Gap, the Productivity Commission described government progress implementing the Agreement's Priority Reforms as mostly weak. It

found no evidence of systemic change and that Government policy did not reflect the value of the community-controlled sector.

> ‘Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution.’[1]

The Commission noted that few tangible steps had been taken to increase the proportion of services delivered by ACCOs and that there was a need to improve funding to ACCOs to provide more flexible and longer-term contracts that cover full costs of services and reduce reporting burdens.**Error! Bookmark not defined.**

The review recommended designating leaders to promote and embed changes to public sector systems and culture, embedding a responsibility in conditions of employment for public sector employees to improve cultural capability and relationships with Aboriginal and Torres Strait Islander people, and improving accountability and transparency.

NACCHO recommends any changes to scope of practice mechanisms align with the National Agreement and its four Priority Reform Areas.

Introduction

NACCHO supports extending scopes of practice across the medical workforce in line with recommendations from the *Primary Health Care 10 year Plan*, the *National Medical Workforce Strategy 2021-2031* and the *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (Health Workforce Plan)*.

However, it is critical that changes are made in a way that supports multidisciplinary teams working to their collective scope of practice, and extensions to scopes of practice that are appropriately and consistently assessed, implemented and regulated.

This will ensure changes to scopes of practice benefit all stakeholders and do not compromise patient safety and outcomes. Without such measures, fragmentation of care is a significant risk.

While scope harmonisation needs to be coordinated at the national level, at the local level, clinicians working to expanded/full scope of practice cannot work in silos, they must continue to work as an integrated team.

Risks and challenges

State-based Poisons Acts

The Health Workforce Plan includes a suite of actions around harmonisation of medicines authorities, including implementation within consistent clinical governance arrangements by 2026, and specifically for Aboriginal and Torres Strait Islander Health Practitioners (AHPs), aligned to the defined professional scopes of practice.

Recent research has shown that inconsistent jurisdictional medicines authorities can lead to practitioners (in this case, registered nurses), being unable to undertake aspects of the medicines management cycle that their workplace demands (Pennington, 2020), and may also result in

[1] Productivity Commission 2023, Review of the National Agreement on Closing the Gap, Draft Report, Canberra, July.

practitioners working well below or beyond their legal scope of practice. This has clear implications for timely access to medications, and may increase clinical and workforce risk. NAATSIHWP note that an issue identified in consultations on the Aboriginal and Torres Strait Islander Primary Health Care training package concerned AHPs being required to work beyond their scope of practice in being asked to provide mental health support to people with specific needs without adequate training.

The AHP role is also affected by differing regulatory frameworks between jurisdictions. For example, in Queensland AHPs operate with a restrained scope of practice due to state legislation - the Queensland State Poisons Act limits the ability to perform immunisations. Our Member services in Queensland have indicated that the inability for AHWs and AHPs to work to their full, trained scope of practice contributes to the attrition of highly trained and capable Aboriginal staff who find the limitations on their roles frustrating.

During the COVID-19 pandemic, extensions to legislated scopes of practice were enacted in several jurisdictions to support a surge vaccine workforce. This was successful such that there are moves to make this a permanent change in some jurisdictions.

Alignment of Poisons Acts and other medicines authorities will support a consistent national approach and allow AHPs and nurses to work to their full, trained scope of practice across jurisdictions. The Health Workforce Plan highlights the importance of aligning scopes of practice nationally, and of harmonising medicines authorities to ensure consistent clinical governance arrangements across the country.

Disparities in jurisdictional approaches also impacts script provision. For example, regulations regarding prescription of Section 8 medications varies across jurisdictions, impacting access to treatments for conditions such as ADHD. This requires both clients and practitioners to navigate multiple complex systems and laws, particularly in remote and border communities where movement of clients is common and where staff may provide locum services and visiting health services across borders. Access to medications can be further complicated by the fact that some jurisdictions do not honor prescriptions from other jurisdictions. The recently released report on Assessment and support services for people with ADHD recommended implementation of uniform prescribing rules (Recommendation 5).

Regulation

Scope of practice is traditionally defined by professional standards, code of ethics and professional conduct and includes skills that an individual practitioner is “educated, authorised, competent and confident to perform”. It is generally determined in consultation and with guidance from the relevant guild to ensure competence to offer these services. Recent moves by pharmacists to expand their scope of practice to include prescribing has not been done in consultation with other guilds or professional bodies. It is not appropriate for pharmacists to determine their own scope of practice to prescribe. Medical professionals should also be involved in setting this standard. Pharmacists do not have the holistic medical training required to safely diagnose and prescribe. The duration and specificity of pharmacy training is inherently incomparable to the up to 12 years of training undertaken by a doctor.

Using this definition, the expanded scope proposed for pharmacists is clearly out of scope with current practice as it requires both changes to legislation, and a minimum of an additional year of education for pharmacists to perform activities such as prescribing. It is critical to ensure any moves

toward pharmacist prescribing are supported by comprehensive primary health care in an ACCHO setting, rather than community pharmacists having full autonomy.

As noted above, NACCHO supports medical professionals working to their full scope of practice, and supports extensions to scopes of practice which are appropriately determined and accredited. Advance practice settings require people with adequate qualification and skills, and there are already strong examples of extended scopes of practice for pharmacists in particular.

The Home Medicines Review Program for example has always required additional study and accreditation for pharmacists to participate – such measures are critical to ensure patient safety and must remain.

The Integrating Pharmacists within Aboriginal and Torres Strait Islander Community Controlled Health Services to Improve Chronic Disease Management (IPAC) is another validated model of expanded scope activities that supports cost effective delivery.

In addition, the separation of commercial interests and dispensing roles is a central part of Australia's healthcare system, it helps safeguard patient safety and must be maintained. The ability for states to bypass national rules, such via state funding mechanisms undermines patient safety and may encourage profit-driven behaviour to be prioritised over consumer safety. For example, recent changes in Victoria allow pharmacists to dispense contraception and prescribe antibiotics for UTIs limits the opportunity for follow up care as well as opportunistic screening and health review that would be undertaken by a GP.

The majority of Aboriginal and Torres Strait Islander patients access medications at a subsidised rate through the PBS and under the fee reduction CTG measure. Current extended scope prescribing models are not covered under PBS or MBS, this risks worsening the medication access gap for many vulnerable Australians.

Bias

Ideally, all health professionals work in a clinical environment that supports people to practice their full set of skills. However, we know there is a sense of tribalism which fragments primary health care and that many clinicians do not know what the full scope of practice looks like for their colleagues and in some cases, disregards people's clinical skills.

The National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) notes that there is a poor understanding of what AHPs are trained to do, particularly among medical professionals such as nurses and GPs. As above, we know that inability to work to full scope of practice is a frustration for many AHPs which can exacerbate issues of retention. Moreover, AHPs cultural knowledge which contributes significantly to patient's engaging in the primary healthcare system is often unacknowledged. Bias in the workplace contributes to this. Research has shown that in addition to building supportive, culturally safe workplaces, clearly documenting and communicating roles, scope of practice and responsibilities, and ensuring that employees are appropriately supported and remunerated will contribute to staff retention.[2]

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[2] Lai, Genevieve C., Emma V. Taylor, Margaret M. Haigh, and Sandra C. Thompson. "Factors affecting the retention of indigenous Australians in the health workforce: a systematic review." *International journal of environmental research and public health* 15, no. 5 (2018): 914.

One of our Members, Apunipima Cape York Health Council (Apunipima), has implemented a simple and practical measure in the form of posters that outline for other staff what the scope of practice is for key clinical roles, including AHWs, AHPs, nurses and other staff.

It is important that organisations employing new staff understand and acknowledge the skill base the individual holds. In the context of the ACCHO sector this includes both cultural and clinical skills. This requires in-clinic leadership to promote and support full scope of practice. However, increasing high quality clinical governance and improving knowledge/understanding of clinical governance and training is required across the primary health care sector to ensure that AHWs and AHPs, are meaningfully incorporated in mainstream models of care.

Funding mechanisms don't support coordinated care

The ACCHO workforce is largely multidisciplinary - according to AIHW data from 2021-22 it includes on average, 4 GPs, 6 AHWs/AHPs, 7 nurses/midwives, 2 allied health professionals, 0.5FTE non-GP specialists, 4 SEWB workers and a dentist. However, alternative models of care like the multidisciplinary team care offered by ACCHOs, require MBS items to better support this way of working.

MBS funding is GP-based and likely to remain so. However, changes to increase the range of billable items that are available to AHWs and AHPs and to practice nurses would support those professions working to their full scope. Currently, most items need to be billed through the GP or not be paid. During the pandemic, the item for COVID vaccines was expanded to allow other professions to administer independently with oversight. Work is required on a funding mechanism that better supports improved and appropriate clinical governance to facilitate approaches like this.

Funding incentives other than MBS can also work to bring in other workforce. The Workforce Incentives Program (practice stream) is inadequate to support multidisciplinary team care at just $130k per practice. However, through My Medicare and Voluntary Patient Registration (VPR) there are opportunities to better align funding with patient cohort need and multidisciplinary teams to support that need.