RURAL DOCTORS ASSOCIATION OF AUSTRALIA

SCOPE OF PRACTICE REVIEW

Response: Issues paper 1

About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.

RDAA has prepared the below information to provide some overarching feedback on the Scope of Practice Issues Paper 1 document, as well as respond to the specific consultation questions.

General feedback

There is a lack of recognition of the context of rural and remote clinical practice and how that may impact on a health care professional's scope of practice.

The Issues Paper constantly refers to non-medical professions and their scope of practice, however there is a lack of recognition of the challenges within the medical profession's views on scope of practice. This hinders access to care, particularly for patients in rural and remote communities.

Within medicine a recent culture has emerged that rural and remote patients should expect to travel in order to access care provided by consultant specialists. However, access to care close to home (within the appropriate risk framework) has better health outcomes than centralising services in a large regional or tertiary service, and with the emergence of a highly trained and skilled Rural Generalist (RG) workforce, capable of delivering higher level care, has failed to be recognised by many metropolitan based consultant specialists.

RDAA members provided feedback that the references to the National Health Service (NHS) in the United Kingdom, is not ideal, as the system is currently under significant pressure. Also the review may have missed the opportunity to explore what underpins the strong primary care models in Scandinavian countries.

There is an important clarification to be made in the report and that it is It is critical to recognise the difference between full scope of practice, practice at top of scope and expansion of scope. Reforms focused on top of scope have a potential to appropriately allow practitioners to increase services at this level. There are potentials though for unintended consequences. Moves toward top of scope could potentially decrease availability of standard care. Additionally, changes to scope of practice has potential to create friction where there is increased overlap in scope which must be recognised and accounted for.

With proposed changes to scope of practice, there must be investment to support the infrastructure that will facilitate communication across the multidisciplinary care team and in training programs that aligns with the model and which should be designed to maximise local recruitment. Without this there will be continued and increasing siloing of services and fragmentation of care.

Legislation and Regulation

Questions for further consultation:

- What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice?
- To what extent do you think a risk-based approach is useful to regulate scope of practice (i.e., one which names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than named professions or protected titles)?
- What do you see as the key barriers to consistent and equitable referral authorities between health professions?

Key areas of legislative and regulatory reforms which could support health professionals to work to full scope of practice are:

- Reviewing the approach to named professions or protected titles in Commonwealth, state and territory legislation.
    - The suggestion of legislation recognising the overlapping nature of scope of practice across different professions would enable developments in innovative workforce models that are not hindered by legislation based on old models of care and workforce design.

      However, this needs to be done with consideration the processes for endorsement as well as other infrastructure improvements.
- Streamlining processes for endorsement.
    - While the document refers to the non-medical professions, it is just as important within medicine, particularly as the RG model continues to grow as a key part of the rural and remote workforce solution. RG doctors have skills in general practice, emergency care and at least one area of advance clinical practice such as obstetrics, mental health or paediatrics.
- Greater harmonisation in referral authority.
    - RDAA is very supportive of this recommended area of improvement. For scope of practice to be meaningful the clinician must have the ability to order tests and treatments that would fall within their scope. Accountability for the same would also be expected.
    - Links to electronic records such as My Health Record to minimise any potential duplication of diagnostic requests is critical for management of the budgetary implications of expansion of the referral authorities. It will also be critical that results of diagnostic requests are available to the multidisciplinary team, unless privacy is specifically requested by the consumer.
    - It is important that with changes to scope of practice there is a link to accountability. Currently the referral/requesting of diagnostics is very reliant on a medical practitioner. If the medical practitioner is the only one accountable for the diagnostics ordered and the follow up of care, this can lead to issues impacting on

inter-professional collaboration and communication. An option may be to remove the referral process for a limited range of consultant specialists eg obstetrician, paediatricians, and psychiatrists, but retain the arrangement for others eg surgeons.

Employer Practices and Settings

Questions for further consultation

- What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)
- Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?
- How can multidisciplinary care teams be better supported at the employer level, in terms of specific workplace policies, procedures, or practices?

It is essential that before processes such as credentialling are further expanded that that the current infrastructure issues are addressed. RDAA has long advocated for a central repository for employment or credentialing documentation due to the duplication required when working across multiple health service districts. If primary care was to have credentialing processes introduced, this becomes critically important, as we are aware that the administration burden limits the mobilisation of the workforce, so it's important that if this was to proceed, the infrastructure is there to support it and not create another barrier.

While this section identified the non-medical scope of practice issues it fails to recognise or mention the issues within medicine, particularly relevant to rural generalist scope of practice. This is relevant to credentialing processes where rural generalists are often have their scope of practice limited at a local level by the personal views of consultant specialists, yet at another hospital are able to provide a broader range of services. The risk for primary care credentialing, is that city based general practitioners or other health care professionals may not understand the context of rural and remote clinical practice and limit a rural and remote clinicians scope based on a metropolitan approach to healthcare.

It is important to note that there are current pilots of Single Employer Model, particularly targeting rural generalist medical practitioners who are employed by the State Health service and work across the primary and secondary care settings. While it is currently a medical initiative the potential, particularly for rural and remote clinicians, it is a significant reform opportunity and deserves mention in the Scope of Practice report.

Education and Training

RDAA would like the importance of context of practice noted as a key element in education and training. We are aware that this issue has been raised repeatedly throughout the consultation

process yet has not been mentioned in this report. It is particularly relevant to the Education and Training component as it must be recognised that a significant portion of health care professionals will train in capital cities or large regional centres, where escalation/transfer to a higher level of care is more accessible than in rural and remote settings.

While the barriers identified in the Issues Paper regarding interprofessional collaboration and communication are all valid, they can also be misinterpreted as the issue when newly trained or newly recruited health care professionals are working with a new rural or remote health care team for the first time.

There is a need for a transition period for new health care professionals to adapt their skills and knowledge to a rural and remote context, particularly in relation to a context of reduced levels of readily available resources in comparison to those available to clinicians in regional centres and capital cities.

Rural and remote doctors recognise the value of a highly skilled and well-trained multidisciplinary team, and are supportive of all clinicians training and working to their full scope of practice however the context is critically important. When speaking to clinicians who have worked in a rural or remote area for a period of time, they will all quickly share insights into the value of the supportive team and the importance of supporting each other, however the level of trust in other clinicians needs to be earned. There will be an expectation of knowledge and skills, however in the application of these in a rural or remote setting needs to be demonstrated in order to build confidence across the team. Clinical errors in a small community can have significant impacts on the trust of the health services, and there is no anonymity for the health care workers in these communities.

Investment into training to support multidisciplinary learning is critical. RDAA would also recommend that investment to rural and remote training programs which will enable the context of rural and remote practice to be embedded into the model and enhance local recruitment and retention of highly skilled clinicians.

Questions for further consultation

- What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope?
- How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?

From a rural medical practitioner perspective the challenges and barriers are often caused by the increasing siloed approach to training, where the focus is on training to top scope rather than full or whole of scope.

For example, medical students need to be included in the care team for antenatal and postnatal clinics, as midwifery students are. While medical practitioners may eventually sub specialise in complex acute obstetric care, gaining the foundation skills of providing care for a "normal" pregnancy or birth is critical. It also should be noted that continuity of care is often only referenced in relation to the midwife, however in a rural and remote setting a GP or Rural Generalist with obstetric skills may be the ultimate provider in continuity of care, as the mother may be a long-term patient of the GP, who could also be the health care provider for the entire family. Involving the GP or RG in pregnancy care, should be a mother's choice, not mandated by a system-preferred model of midwifery care.

Accreditation of supervision should recognise other health care professionals have the skills and knowledge to provide supervision at various levels of clinical practice.

Funding models

RDAA has made previous submissions regarding the funding model for general practice and that the fee-for-service model is no longer fit for purpose. RDAA has encouraged Government through the Strengthening Medicare Taskforce to explore a funding model for general practice that would include block funding, a level of activity-based funding, and also incentives for quality outcomes.

Questions for further consultation

- How could funding and payment be provided differently to enhance health professionals' ability to work to full scope of practice, and how could the funding model work?
- Which alternative funding and payment types do you believe have the most potential to strengthen multidisciplinary care in the primary health care system?
- What risks do you foresee in introducing alternative funding and payment types to support health professionals to work to full scope of practice, how do these risks compare to the risks of remaining at status quo, and how might these risks be managed?

RDAA warns against an expansion of the current Medicare Benefits Schedule fee-for-service model as the mechanism to support full scope of practice by the multidisciplinary team. It is a current risk to the viability of rural and remote general practice and RDAA fails to see the model working for other health care professionals in that context.

The other challenge for the current suite of incentives is the Workforce Incentive Program Practice Stream is only available where the nurse, allied health professionals or Aboriginal Health Workers are employed in a general practice. Particularly for allied health professionals with greater scope for setting up an independent business, while they may have strong connections with a general practice and provide excellent multidisciplinary care, they are not eligible to receive the WIP Practice Stream incentive or any other similar incentive. This is unfair and extremely limits its application to support multidisciplinary care.

The maldistribution of the medical workforce extends through to allied health care professionals, pharmacists, and nurse practitioners. Rural GPs and RGs see the value in working in a fully staffed multidisciplinary care team that can provide services across primary and secondary care settings. This will ensure the work remains interesting and clinicians remain able to utilise the breadth of their skills to provide care that meets the needs of their communities.

The health outcomes of people living in rural and remote Australia are worse than those living in cities, with the lack of access to care a major contributing factor. New models that will enhance engagement of these clinicians in our communities is fully supported by RDAA.

Technology:

Questions for further consultation

- How do you think technology could be used better or differently in primary care settings to enable health professionals to work to full scope?
- If existing digital health infrastructure was to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?
- What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?

If current health infrastructure is to be improved then the interoperability of general practice and pharmacy systems should include the automatic and seamless loading of information/documentation to My Health Record. This needs to be a requirement of any new software to be approved for market in the future.

State Health Systems interoperability to My Health Record should be a requirement of funding in the National Health Care Agreement.

As previously mentioned in relation to credentialling for primary care it is essential that current limitations in the credentialing infrastructure area addressed before these processes are further expanded; for example, a central repository that multiple employers, colleges and government agencies can access documentation from. If clinicians do not wish to provide access to specific groups, they will either be required to submit hard copy documents or accept the limitations to their practice, depending on policy settings.

Currently the Medicare payment system is antiquated and changes to the system are expensive and, at times, have been identified as a limiting factor to good policy. A new funding model would require a new system, but that change is well overdue and worthy of significant government investment as the status quo of payment systems is becoming more expensive to maintain and an ongoing barrier to reform.