EXERCISE & SPORTS SCIENCE AUSTRALIA (ESSA) SURVEY RESPONSE

RE: SCOPE OF PRACTICE: UNLEASHING THE POTENTIAL CONSULTATION 2

8 March 2024

The second consultation in the federal, independent review to understand the barriers and incentives to allied-health professionals in working to the top of their scope of practice is currently open and will close on 8 March 2024.

ESSA are proposing the following responses to the survey, and members have also been advised about the opportunity to provide their own responses.

There will be an additional 2 consultation processes in 2024.

The first issues paper from the 2023 consultation process can be found here. Many of the ESSA recommendations are highlighted in this issues paper, strengthening our position in effectively influencing change for ESSA members.

Please contact ESSA Policy & Advocacy Advisor, Elyse Hocking on 07 3171 9694 or elyse.hocking@essa.org.au for further information or comments.

Yours sincerely,

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Which of the following perspectives best describes your interest in the Scope of Practice Review?
Dropdown box: Peak/regulator

Section A: Legislation and regulation

1. **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? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently.)**
   Open written section, 1,000 *characters* limit
   - State and federal legislations that specify Aphra registered professionals must recognise self-regulating allied health professionals.
   - Recognition of National Alliance of Self-Regulating Health Professions (NASRHP) standards with nationally recognised definitions for self-regulating and unregulated professionals
   - Harmonisation with state and federal legislations to remove jurisdictional inconsistencies is critical to an equitable, and consistent allied health workforce to effectively support the primary health industry in Australia
   - Removal of legislative barriers that dictate specific professions are eligible to access promotions or carry out work. Implement legislation that dictate that health services can be accessed by 'appropriately qualified and skilled allied health professionals.'
   - Remove legislative barriers that dictate GPs are the only professionals able to refer patients/clients.
   - Consistency across compensable schemes to remove legislative barriers that prevent professions from being able to deliver to their full scope of practice. *(926 characters)*

2. **A risk-based approach to regulation names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than relying solely on named professions or protected titles. To what extent do you think a risk-based approach is useful to regulate scope of practice?**
   To a great extent
   Somewhat
   A little
   Not at all
3. **Please provide any additional comments you have on the risk-based approach to regulation.**
   Open written section, 1,000 *characters* limit
   - This is a critical reform in achieving an accessible, equitable and effective primary health system in Australia. There must be a nationally agreed definition on the

risk-based framework and consultation with all peak professional bodies. This includes both regulated and self-regulated as part this reform to develop the framework.

- An appropriate educative element must accompany the reform to ensure that its implementation is consistent, and equitable, regardless of the setting, or which professions are in leadership roles at the time.
- Consideration needs to be provided to fund organisations with strong risk-based approaches already in operation for lower risk professionals such as the National Alliance of Self-Regulated Health Professions.
  (*460 characters)*

4. **What do you see as the key barriers to health professionals' authority to make referrals across professions?**
   Open written section, 1,000 *characters* limit
   - Without a nationally defined and agreed framework between professions, referrals across professions will be limited to perceptions about others scope, and not based on facts about actual skills and scope.
   - Without an appropriate implementation of the above-mentioned framework, there is a high likelihood of continued 'turf war' between some professions that will limit appropriate, effective, and consistent referrals
   - Accredited Exercise Physiologists (AEPs) must be included as a profession authorised to make direct referrals. This is a critical element in rural and remote locations and small group settings, particularly for those people with chronic illness and pain, and mental illness. The ability to directly refer to other appropriately qualified professionals in these circumstances would have a significant positive impact on consumers and reduce the burden on GPs, reducing cost and shifting the current model towards delivering value based healthcare.
   - There must be mutual recognition between interprofessional knowledge and acceptance of physical therapies professions scopes. Physical therapists include AEPs, chiropractors, osteopaths, and physiotherapists.
   - Appropriate categories and work classifications Eg. Updating of ANZSCO work classifications for allied health to reflect a modern Australian labour market will assist in increasing recognition
     (*972 characters)*

<u>Section B: Employer practices and settings</u>

All open written responses, with 1,000 *character* limits

1. **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)

- Jurisdictional inconsistencies remain a barrier with scope being determined by individual workplaces rather than a national, agreed definition of scope, and clinical governance, plus adequate interprofessional training.
- Industrial agreements where leadership roles and additional opportunities are based on appropriate qualifications and experience, not specific job titles or professions.
- Referrals for Accredited Exercise Physiologists (AEPs) should never have to go through a Physiotherapist, yet this is currently common practice.
- Appropriate funding to support effective, existing models of multidisciplinary care to be consistently implemented regardless of employer setting.
- AEPs to be able to access roles they are appropriately qualified for Eg: leadership opportunities often specify Physiotherapy, missing an opportunity for an equally qualified allied health workforce.
- Multidisciplinary teams are the way forward to deliver an effective, modern, value based healthcare system.
- Additional FTE roles for a strong allied health workforce - an important step towards removing casual roles.
  (953 characters)

2. **Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?**

   - Using a nationally agreed, scope and definition of skills-based assessments to determine which workforce can deliver programs. Eg Accredited Exercise Physiologists (AEPs) can perform Activities of Daily Living Assessments (ADLs) for WorkCover in Queensland, but cannot in NSW or SA Workers Compensation Schemes.
   - Again, we are looking for equal recognition of skills and competencies, not titles.
   - This imperative shift, creates a stronger, more productive and satisfied allied health workforce, reduces burnout and increases consumer accessibility, with lower wait times. Additional, evidence-based programs can run, and assist more people in both prevention and maintenance of chronic health conditions, chronic mental illness, and chronic pain.
     (707 characters)

3. **What can employers do to ensure multidisciplinary care teams are better supported at the employer level, in terms of specific workplace policies, procedures, or practices?**
   - Supporting case conferencing, supporting multidisciplinary teams interprofessional training and understanding of one another's scope and how to compliment other profession's work, reducing turf war and lack of understanding of the benefits of effective teams.

- Supporting working together collaboratively at all stages of client/patient care, specifically in care planning stages wherever appropriate.
- All settings to have policies and procedures, with effective training attached, to fully understand all members roles and maximise work efficiencies.
- Ensuring leadership and progression opportunities are available to all appropriately qualified and skilled allied health professionals, and not just a few specific ones.
- Encourage and incentivise diversity within leadership roles to build the required culture shift.
- Provide meaningful, ongoing professional development opportunities, including team building and interprofessional training.
  (828 characters)

Section C: Education and training

1. **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? You may select multiple responses.**
   Availability of learning institutions
   Employer support for learning
   Availability of supervision and mentoring
   Quality of training
   Time burden
   Other
2. **If you chose 'other', please provide details.**
   Written, 1,000 characters

   - Funding is an additional barrier as self-regulated peak bodies do not receive Government funding to develop equivalent data. EG: The Terms of Reference for the Scope of Practice project refers to Kruk report. However, this report was specific to regulated health professions only. The review of the National Alliance of Self-Regulating Health Professions (NASRHP) Standards is underway, however inequalities in the funding available for self-regulatory bodies like NASRHP and its members means that there cannot be the same type of evidence produced as the Kruk report.
     (*571 characters)*

3. **To what extent do you think health professionals' competencies, including additional skills, endorsements or advanced practice, are recognised in their everyday practice and are known to consumers?**
   To a great extent
   Somewhat

A little

Not at all

4. **How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?**
   Written, 1,000 characters

   - Incentivising high performing multidisciplinary care teams
   - Providing meaningful, ongoing and consistent interprofessional training opportunities as part of required Professional Development points for all professions/team members.
   - Incentivise diversity in leadership positions and knowledge sharing.
   - Value placed on understanding of other's scopes and effectively leading multidisciplinary teams as a result. This may be done via skills endorsements as an example, but would need to be based on a national, agreed framework with agreed definitions that are used consistently and equally.
     (570 characters)

Section D: Funding policy

Funding mechanism categories
Fee-for-service: *payment for each episode of care.*
Block funding: *lump sum payment allocated to service provider.*
Bundled funding: *single payment for all services related to a specific treatment, condition or patient parameter, possibly spanning multiple providers in multiple settings.*
Blended funding: *combination of funding streams, such as block/bundled plus fee-for-service.*
Capitation: *payment based on the number of patients enrolled or registered with the practice.*
Value-based care: *Payments which link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics.*
Program grants: *lump sum payment allocated to a specific program.*
Salaried workforce: *health professionals earn a salary rather than being funded through one of the above funding mechanisms.*
Delegated funding: *a term which appeared through consultations, which refers to practices where a named health professional delegates activities related to care to another health professional, but receives payment for that service.*

1. **Are you aware of specific instances where funding and payment could be provided differently to enhance health professionals' ability to work to full scope of practice? Please provide specific examples.**

   Written, 1,000 characters

- Ahpra have endorsements for credentialling, but self-regulating professions are lacking this option due to inadequate and inequitable government funding to be able to do the same work. An opportunity to fund the National Alliance of Self-Regulating Health Professions (NASRHP) to create a competency map that would sit across multiple professions to strengthen and streamline the primary healthcare system is a valid option.
- Funding mechanisms inconsistencies should be removed. Eg: The Workers' Compensation Scheme in NSW doesn't allow AEPs who work as Rehabilitation Consultants to conduct Assessments of Activities of Daily Living (ADLs) but the Workers' Compensation scheme in Queensland does. This is a missed opportunity in NSW to have a similarly skilled workforce provide access to services and reduce wait times for injured workers. The National Disability Insurance Scheme (NDIS) are also missing this opportunity, not allowing AEPs to perform Assessments of ADLs.
  (979 characters)

2. **Which alternative funding and payment type do you believe has the greatest potential to strengthen multidisciplinary care and support full scope of practice in the primary health care system?**
   Block funding
   Bundled funding
   Blended funding
   Capitation
   Salary
   Program grants
   Other
   None
   If you selected 'other', please provide details. (1,000 characters)

   - It is important to acknowledge that the employment setting makes a difference, which professions are making up multidisciplinary care teams and which conditions are being treated. A blended funding approach seemingly is the most fitting solution as a result.
   - Eg: In a private setting, there is typically less access to coordinated multidisciplinary care teams in the same workplace;
   - Eg: In rural and remote settings, access to health professionals is very different, and requires different frameworks for equal outcomes
   - Eg: Different conditions require different professions involved in multidisciplinary teams. Eg. diabetes care should involve AEPs + dietitians, diabetes educators + podiatrists at a minimum
     (711 characters)

3. **How do you believe your selected funding type(s) could work to resolve barriers to health professionals working to full scope of practice?**
   Written, 1,000 characters

   - Ensuring the inclusion of telehealth in all funding models to provide an equitable, consistent approach.
   - Community health and primary care are integrated with hospital care, to improve the consumer/patient care journey and consistency in their care regardless of settings.
   - Funding based on tasks and/or skills and competencies, rather than professions to increase consumer/patient access and reduce waiting times and turf wars. *(419)*

4. **To what extent do you believe alternative funding policy approaches create risks or unintended consequences?**
   To a great extent
   Somewhat
   A little
   Not at all
5. **How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?**
   Written, 1,000 characters

   - There must be adequate funding to ensure that professionals are engaging in the funding mechanism. Eg: DVA, and MBS have seen a decline in use due to unfavourable fee schedules compared to other compensable schemes. This reduces access and choice for patients/consumers.

Section E: Technology

All written responses, 1,000 characters

1. **How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?**

   - Currently, the technology in use is not an effective tool in supporting health professionals to work to full scope. There needs to be a national, unified approach, with access to consumer records being shared simply, consistently, timely, and equitable to all professions who need the information.
   - Establishing access to real time information is critical, with access recognised for all who need it, not limited to Ahpra registered professionals. Eg: Digital imagery viewing is currently limited to Ahpra registered professions.

- My Health Record access for smaller providers is not equitable or consistent. It is challenging for self-regulated health professionals to access a Health Provider Individual Identifiers to able to upload information to the My Health Record.

(827 characters)

2. **If existing digital health infrastructure were to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?**

- Improved access for self-regulating professions to access HPI-I numbers as a priority.
- Clearly outlined measures to ensure data accuracy and data storage safety to gain user and consumer confidence.
- Clearly defined processes and framework around digital referrals – ensuring that digital referrals are nominated by appropriately qualified and skilled professionals, and not by job titles or professions.
- Incentivise sharing information between professions to ensure best practice multidisciplinary care teams.
- Ensure small business have equitable access to conformant software.
- Development of appropriate conformant software that is easy to access, cost effective, and user friendly.
- Appropriate and meaningful training must compliment technology advancements.

  (778 characters)

3. **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?**

- Risks are primarily around cost. Equitable access and effective, wide-spread implementation with efficient continued use. The solution is not straight forward and requires a unified, national approach with the basics set before continuing the current trajectory. Small business with limited capacity maybe be at a disadvantage, due to cost of purchase and adoption of new technologies. This may also be prohibitive for some consumers too.
- Adoption by consumers and users is currently low due to lack of confidence in data storage safety, and lack of understanding how and why personal data is being used, stored, and shared between professions.
- There must be a consistent, unified approach to technology that is complimented by education and training for health professionals (large and small business), and for consumers.
- Risks of inequitable access remains high; legislation must include self-regulating professionals and ensure access is not dependant on setting or specific

professions.
(947 characters)

If space is available:

Thank you for the opportunity to engage in this important consultation process. Exercise & Sports Science Australia (ESSA) can provide further detail and would welcomes a meeting to discuss the AEP scope of practice with the Department at any time. Please contact ESSA Policy & Advocacy Advisor, Elyse Hocking on 07 3171 9694 or elyse.hocking@essa.org.au to arrange this.