Avant
By doctors for doctors

Avant Mutual Group Limited
ABN 58 123 154 898

Registered office
Level 6, Darling Park 3
201 Sussex Street, Sydney NSW 2000

Postal address
PO Box 746 Queen Victoria Building
Sydney NSW 1230

DX 11583 Sydney Downtown

avant.org.au

Telephone 02 9260 9000 **Fax** 02 9261 2921
Freecall 1800 128 268 **Freefax** 1800 228 268

24 May 2024

By email: scopeofpracticereview@health.gov.au

Scope of Practice Review – Issues Paper 2

Thank you for the opportunity to provide this response to the Unleashing the Potential of our Health Workforce: Scope of Practice Review consultation on Issues Paper 2.

Our submission is attached.

Avant acknowledges the ongoing work of the Scope of Practice Review and welcomes the opportunity for further engagement with the Review.

Please contact Suzanne Mercer on the details below if you require any further information or clarification of the matters raised in the submission.

Yours sincerely

Michael Wright

Dr Michael Wright
Chief Medical Officer
Email: michael.wright@avant.org.au

Suzanne Mercer
Corporate Affairs Manager
Email: suzanne.mercer@avant.org.au

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Avant Submission to the consultation on Scope of Practice Review – Issues Paper 2

Avant is a member-owned doctors' organisation and Australia's largest medical indemnity insurer, committed to supporting a sustainable health system that provides quality care to the Australian community. Avant provides professional indemnity insurance and legal advice and assistance to over 85,000 medical practitioners and students around Australia (more than half of Australia's doctors). Our members are from all medical specialities and career stages and from every state and territory in Australia.

We assist members in civil litigation, professional conduct matters, coronial matters and a range of other matters. Our Medico-legal Advisory Service provides support and advice to members and insured medical practices when they encounter medico-legal issues. We aim to promote quality, safety and professionalism in medical practice through advocacy, research and medico-legal education.

General comments

Avant welcomes the Review's acknowledgement in Issues Paper 2 of the necessity for all primary care health practitioners to maintain their own indemnity insurance coverage – a position we have long advocated for that reassures patients and practitioners alike that any professional indemnity issues can be adequately addressed should they arise.

However, Avant has identified several concerns regarding potential impacts on patient safety and quality of care in the reform options proposed by the Review. These concerns include:

- An emphasis on practitioner-focused tasks and activities rather than relevant patient outcomes and multidisciplinary team-based care.
- Safety implications of proposed changes to education, including suggestions of minimal supervision for healthcare graduates working in primary care.
- Risk of care fragmentation and reduced patient safety due to additional referral pathways without automated sharing of e-health records.
- Lack of clarity in funding proposals regarding the oversight role of GPs in multidisciplinary teams, potentially affecting continuity of care and viability of existing practices.
- Insufficient clarity and detail in some proposals, such as the proposed National Skills and Capability Framework and Matrix.

In previous submissions to the Review, we have advocated strongly for GP-led multidisciplinary team-based care as an effective pathway that benefits patients and enables health professionals to work together safely to their full scopes of practice in primary care. This position builds on the recommendations of the Strengthening Medicare Taskforce and recognises the crucial role that GPs play as facilitators and advocates for their patients, providing leadership, clinical oversight, and continuity of care to their patients and to their practice team.

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Avant firmly believes that the Review must prioritise safe, collaborative, and patient-centred primary care, and focus on enabling GPs and other primary care health professionals to work to their full scopes of practice in GP-led multidisciplinary teams.

Further, Avant strongly recommends the adoption of a "systems thinking" approach to enabling an effective and safe scope of practice regime. Reviewing scope of practice without considering the enabling components of the broader health system can lead to fragmented care, increased costs, practitioner animosity, and sub-optimal patient outcomes.

The regime should clearly define the role of GPs as central coordinators of multidisciplinary teams, guiding collaborative efforts within well-defined scopes of accountability. To support this, a robust system of enablers is necessary to facilitate integration and cooperation across healthcare disciplines.

Key enablers include technology for efficient information sharing and coordination, comprehensive data analytics to inform decision-making, and continuous training to keep all team members at the forefront of best practice. Additionally, fostering a positive team culture enhances collaboration and mutual respect among health practitioners, while incentive structures aligned with quality care and team performance motivate practitioners to deliver their best work.

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Responses to Issues Paper 2

1. Leadership in primary care

Q. What leadership do you consider important to ensure reforms are successfully implemented? For example, what is required at the professional, practice, organisation and/or profession level?

Leadership within multidisciplinary teams in primary care must support patient safety and quality of care. General practitioners already play a key leadership role day to day in coordinating holistic comprehensive care, particularly for those with chronic or complex conditions. Enabling more team-based care led by GPs will support all primary care health professionals to work together to their full scope of practice while preserving the continuity of care, care coordination and holistic knowledge which are the core skills of GPs.

At the practitioner level, effective leadership, by a GP, in a multidisciplinary care environment plays a pivotal role in fostering teamwork, improving patient outcomes, and promoting a culture of innovation and continuous improvement. The leadership model in such a setting should have several key principles that guide the actions and behaviours of health practitioners across disciplines. Those principles should include:

- Team co-ordination – GPs serve as central point of coordination for multidisciplinary teams.
- Patient advocacy – GPs advocate for the best interests of patients as trusted advisor and primary contact point.
- Clinical oversight – GPs have oversight of patient care by other team members.
- Accountability and indemnity – individual health professionals in the team are accountable for the activities they perform within their scope of practice and have their own indemnity insurance to cover this.

At an industry level, leadership will be required from multiple stakeholder groups to navigate the inevitable complexities that reform will create.

For example, leadership on indemnity arrangements will be critical to the success of any reforms, with implications at professional, practice, organisation and professional levels. Indemnity arrangements also need to be designed before new models of care are implemented so that practitioners have cover for the care they provide, and any indemnity questions can be appropriately addressed should they arise. Professional indemnity insurance is essential for health professionals to be able to practice, as the Review has acknowledged in Issues Paper 2.

Moreover, strong leadership that embraces the complexity of scope of practice and collaborative care, the multiple primary care professions involved, and strong clinical governance and patient safety will be essential to guide successful reform.

This will be required across the reform journey, from detailed design through implementation to integration and ongoing assessment. It should span jurisdictional and geographic areas, including rural and remote regions given their specific needs. All primary care stakeholders, including medical indemnity providers and GP and practice representatives, should be involved to prevent gaps and flaws in design and implementation.

The Commonwealth Government should implement any reform process only after careful design and consultation, guided by an expert advisory group. The expert advisory group comprised of representatives from government departments, all health professions and provider stakeholders engaged in primary care (including indemnity providers), education providers and accreditation stakeholders, and consumer health groups should be convened to set a vision and framework for the proposed changes. This group should be separate from and precede the independent national body proposed by the Review to assess evidence and inform future scope of practice reforms. Any reforms also must be evaluated.

The leadership required to guide implementation will depend on the specific initiative, the outcomes of detailed design, and the stakeholders directly involved in implementation. Importantly, decisions about leadership and change management to support implementation should be a core consideration in the detailed design process.

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2. Workforce design, development and planning

Options for reform developed in relation to workforce design, development and planning are:

- *National Skills and Capability Framework and Matrix*
- *Develop primary health care capability*
- *Early career and ongoing professional development includes multi-professional learning and practice.*

Q. To what extent do you believe the combined options for reform will address the main policy issues relating to education and training and employment practices you have observed in primary health care scope of practice?

- To a great extent
- Somewhat
- A little
- Not at all

Please provide any additional comments.

- **National Skills and Capability Framework and Matrix**

Avant believes that the reform option to create a National Skills and Capability Framework and Matrix must incorporate a focus on safer patient outcomes and well-coordinated care led by GPs if it is to effectively inform workforce planning and support the day-to-day functioning of multidisciplinary teams in primary care.

To date, the Review has outlined the proposed purpose of the Framework and Matrix and how it might be developed in very broad terms. There is, however, limited information about the design principles for the Framework and Matrix, and we are concerned that there is an undue emphasis on practitioner-focused tasks and activities rather than relevant patient outcomes and multidisciplinary care. While an obvious focus for the Framework and Matrix should cover clinical competencies, it should also focus on embedding collaborative competencies such as teamwork, leadership and conflict resolution in those areas that require multidisciplinary collaboration. It is also important that the Framework and Matrix is not merely a list of skills and competencies. For it to work effectively to ensure good patient outcomes, it must recognise the key role of the GP in coordinating the holistic care that a patient may need, including assimilating information in the diagnostic process, managing uncertainty when diagnosis and treatment pathways are unclear, and balancing the complex needs of those with multimorbidity.

This is illustrated by looking at how the care of a diabetic patient is managed by a GP-led multidisciplinary team (see Diagram 1).

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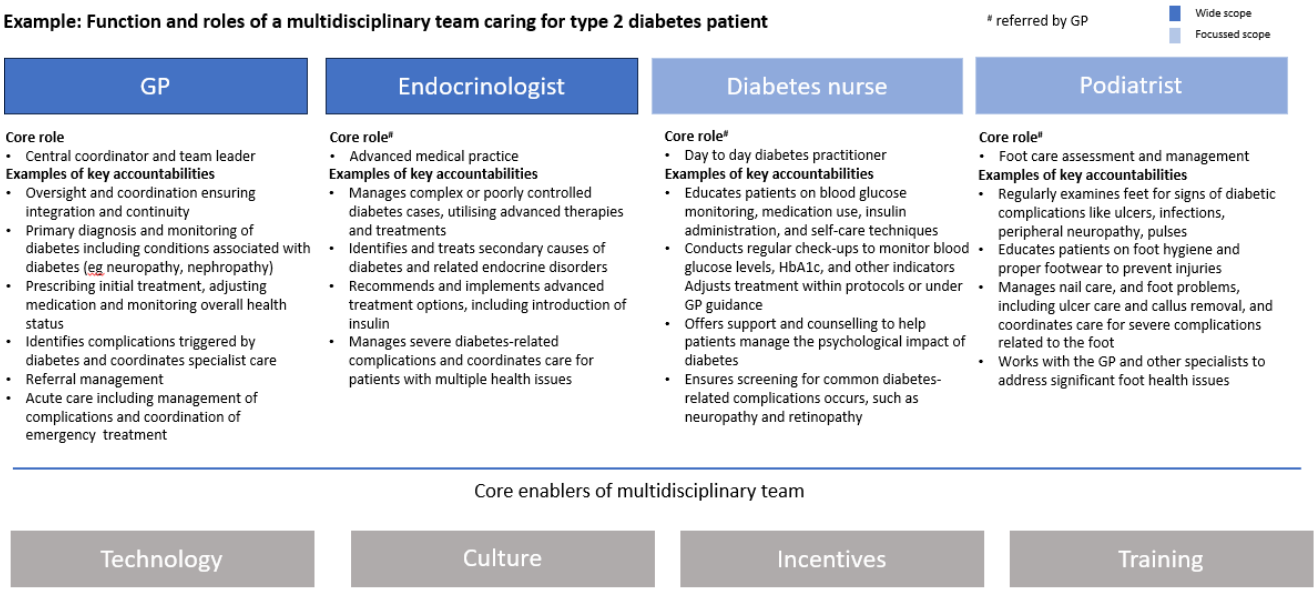
Diagram 1



- **Develop primary health care capability**

We welcome the proposal to develop the collaborative capability of primary care health professionals by increasing supervised practical training (SPT) during pre-qualification education.

Importantly, however, this SPT should not reduce the time available for essential medical sciences theoretical education, nor should it reduce the supervision, mentoring and further education required when early career health professionals are starting to practise (Issues Paper 2, pp41-42). Any such reduction could have implications for standards of care and patient safety.

This is particularly the case for medical practitioners. Both early career doctors (e.g. interns, PGY2) and GP trainees require extensive supervision, mentoring and education "on the job" over many years to be capable and confident of providing healthcare at a reasonable standard. This process cannot be underestimated and cannot be abbreviated. This is supported by the fact that since 1996, Commonwealth governments, GP colleges, the Medical Board of Australia and the Australian Medical Council have worked towards making formal specialist GP training compulsory for all medical practitioners who want to work in general practice, to improve the standards of care provided to patients. Formal training programs include the Australian General Practice Training Program, the rural generalist training programs, the Remote Vocational Training Scheme, the RACGP Fellowship Support Program and the ACRRM Independent Pathway. These programs are extensive and comprehensive, and it is only upon completion of this training that medical practitioners are certified as being able to undertake independent general practice. Any moves to reverse what has been achieved here are very likely to result in lower standards of care received by GP patients.

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Q. How should the National Skills and Capability Framework and Matrix be implemented to ensure it is well-utilised?

A broad consultation process should be undertaken to ensure the Framework and Matrix is comprehensive, relevant and usable. This includes engaging key stakeholders such as medical practitioners, indemnity providers, healthcare administrators, and professional bodies to gather diverse perspectives and ensure the Framework and Matrix meets the needs of all parties involved.

Following the design and consultation phases, the Framework and Matrix should be piloted in a controlled setting to enable the identification of potential issues and areas for improvement. Throughout the implementation, robust feedback mechanisms should be established as well as assessments of effectiveness including patient outcome tracking.

Q. Who do you see providing the necessary leadership to ensure the National Skills and Capability Framework and Matrix achieves the goal of contributing to health professional scope of practice in primary care?

The Australian Medical Council, together with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine, should represent GPs and help lead the development of health professional scope of practice in primary care.

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3. Legislation and regulation

Evidence gathered to date has contributed to three proposed reform options related to legislation and regulation:

- *Risk-based approach to regulating scope of practice to complement protection of title approach*
- *Independent, evidence-based assessment of innovation and change in health workforce models*
- *Harmonised Drugs and Poisons regulation to support a dynamic health system.*

Q. To what extent do you believe the combined options for reform will address the main legislative and regulatory policy issues you have observed in primary health care scope of practice?

- To a great extent
- Somewhat
- A little
- Not at all

Please provide any additional comments.

Generally, Avant agrees with:

- a risk-based regulatory approach to health care regulation; in conjunction with
- revision and change in workforce models to support GP-led multidisciplinary team care; in conjunction with
- harmonisation of the disparate state-based drugs and poisons regulations, incorporating real time prescription monitoring (RTPM) regulation.

To be effective, there must be national agreement by all stakeholders and professions regarding roles and competencies, supported by consistent drugs and poisons regulation across state borders, monitored by RTPM. To achieve this substantial change there will need to be engagement with all primary care professions represented in the multidisciplinary teams.

This significant change to the mode of delivery of health care will also require public education programs to reinforce:

- the competencies of each participant health care provider within the multidisciplinary care team
- the points at which each of the professions involved in multidisciplinary care teams must communicate regarding the status of a patient's care (or non-compliance with treatment recommendations)
- the general practitioner's pivotal role in overseeing the patient's treatment plan and providing a holistic overview of the patient's care.

Given that stakeholders have been agitating for nationally consistent drugs and poisons regulation for some time, this proposal may provide health ministers with the necessary incentive for state and territory governments to agree to legislative change.

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Q. To what extent do these options for reform strike the right balance between maintaining protection of title where appropriate, and introducing risk-based regulatory approaches in specific circumstances?

- To a great extent
- Somewhat
- A little
- Not at all

Please provide any additional comments.

The Review has proposed three solutions that are designed to enable a risk-based approach to regulation of scope of practice that complements title protection, including:

- regulate scope of practice around certain higher-risk or shared activities to be identified by National Boards and Ahpra
- consider amending the National Law to enable Health Ministers to issue policy directions to accreditation authorities directly
- identify legislation limiting scope of practice and work towards harmonisation.

In our view these reform proposals strike a reasonable balance between maintaining protection of title and introducing a risk-based regulatory approach for specific high-risk activities.

While we generally support the policy intent of the risk-based approach to regulating scope of practice around certain higher-risk activities, there can be difficulties defining competencies. Developing competencies around particular activities needs input from relevant professions.

From an insurance perspective, the same activity can have different levels of risk depending on the profession that performs that activity. For example, oral and maxillofacial surgeons are competent to perform particular activities, but undertake different training pathways (dental vs medical) which mean they have different levels of risk for the same activities.

Q. What factors should be considered when implementing the changes to legislation and regulation to ensure they are effective?

In response to the proposal that an independent national body be established to assess evidence and inform future scope of practice reforms, our view is that:

- This independent national body would be separate from the expert advisory group recommended by Avant to support the Commonwealth Government in implementing the suite of reforms proposed by the Review.
- The independent national body should be established before implementing legislative change to ensure that all practical aspects of the reform are considered and to support a nationally consistent approach to legislative reform.

- The national body should be separate from regulatory bodies such as Ahpra to ensure that there are no potential conflicts of interest. However, Ahpra representatives may be part of the national body as regulatory subject matter experts.
- The national body would provide advice and recommendations to government, but not have any decision-making power.

In addition, legislative and regulatory changes should be designed to lessen the administrative burden on GPs so that more time can be spent helping patients.

To facilitate the necessary changes to legislation and regulation, there is a need for patients to:

- understand the function of the proposed multidisciplinary care team
- be clear about the competencies of each health provider within the team
- understand the central role of the general practitioner in overseeing and analysing information provided by team members to facilitate treatment and holistic care.

Key stakeholders in the primary care sector also need to have the opportunity to inform proposed changes to legislation and regulation to prevent gaps and flaws in design and implementation, consistent with standard government processes for legislative change. If any of the facets of the proposed reform are not contemplated or integrated, there is a significant risk that siloed and ineffective patient care will result. Conversely, if there is early engagement, contribution and agreement to the plan by all stakeholders, funded and facilitated by government before initialisation of the reforms, there could be a meaningful change to the delivery of effective patient care.

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4. Funding and payment policy

Two options for reform have been developed relating to the theme of funding and payment policy:

- *Funding and payment models incentivise multidisciplinary care teams working to full scope of practice*
- *Direct referral pathways supported by technology.*

Q. To what extent do you believe the combined options for reform will address the main funding and payment policy issues you have observed in primary health care scope of practice?

- To a great extent
- Somewhat
- A little
- Not at all

Please provide any additional comments.

We welcome the Review's acknowledgement of the need for changes to funding and payment models to support and incentivise multidisciplinary care teams working to full scope of practice in primary care.

In previous submissions, Avant has noted that GP-led multidisciplinary care has been limited by the lack of funding mechanisms for other health professionals to be paid for the work they do in these teams, through Medicare or other means. These funding limitations mean that GPs often manage tasks which could be delegated effectively to other health practitioners in a collaborative team given the right parameters, including funding and payment access. Funding and payment reform should free up GPs to work to their full scope of practice, using their holistic knowledge and core skills in care coordination and continuity of care to lead multidisciplinary teams that best meet patient needs.

Q. What other implementation options should be considered to progress the policy intent of these options for reform?

Avant has the following feedback on the funding and payment policy reform options.

- ***Using block, bundled and blended funding to deliver care flexibly***

We generally support the proposal to introduce blended funding for multidisciplinary team-based care, however many questions remain about how the mechanism would work in practice.

As set out by the Review, we agree that funding should be made available to the GP, practice, practice groups and/or primary care provider organisations responsible and accountable for initiating care, with funding flowing to other members of the multidisciplinary team who deliver care autonomously, consistent with the plan and further guided by their specific scope of practice and ongoing assessment of care needs.

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We also agree that incorporating existing assessment and care coordination MBS items into the blended payment will result in greater flexibility for multidisciplinary care teams operating across multiple sites.

However, there is a lack of clarity in the funding proposal regarding the oversight role of GPs in multidisciplinary teams, potentially affecting continuity of care and the viability of existing general practices. Specific and sufficient funding should be provided to cover the time, effort and resources required for GP oversight, building on the early learnings from the MyMedicare initiative where concerns have been raised about inadequate oversight funding. Relevant Medicare item numbers should be updated to reflect this.

We also continue to recommend having new Medicare items for care coordination (i.e. non-patient facing tasks) to encourage delegation, incentivise team collaboration, and enhance the ability for all practitioners in a care team to work to full scope of practice.

- ***Direct referral pathways supported by technology***

Our view remains that there is value in expanding access to referrals for primary care health practitioners with appropriate expertise, provided implementation supports safe, high-quality patient care by multidisciplinary teams.

We generally support the mechanisms proposed by the Review, including that there is a clear link to the referring professional's scope of practice, the relevant treating team members (including the patient's GP) are notified, and the referring professional is part of the same primary care multidisciplinary team. However, we don't agree that the destination service – for example, radiology, pathology, and other specialists – need necessarily be part of that multidisciplinary team.

In addition, we recommend that the design of direct referral pathways – including the appropriateness of who can refer, and for what – should be determined by the destination services who will receive those referrals. Relying on the advice of these medical specialists will be critical to avoid over-referral to specialists, particularly where the assessment and management of many conditions can be performed adequately by GPs, who would not need to refer patients to other specialists.

We also strongly recommend that implementation should only proceed when digital health technology can be relied on for automated sharing of e-health records and timely collaboration on patient care, particularly for health practitioners in multidisciplinary teams practicing across locations.

Q. To what extent will these policy options support full scope of practice?

See response to question above.

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Q. What additional actions relating to leadership and culture should be considered to encourage decision-makers to work together in a cooperative way to achieve the intent of these policy options?

No response provided.

Q. Are there implementation options which have not been considered?

No response provided.

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5. Last word

Q. Are there additional reform options which have not been considered that could progress the intent of this Review?

We welcome the Review's acknowledgement of the necessity for all primary care health practitioners to maintain their own indemnity insurance coverage. We note however that the Review hasn't canvassed how insurance coverage and associated issues of accountability and liability can be addressed through the proposed reform options.

Clear indemnity arrangements are an essential enabler and safeguard for health practitioners working to full scope of practice, when working independently, in a practice or in multidisciplinary teams in primary care.

In multidisciplinary team-based care, there needs to be a clear understanding about which member is accountable for what and to whom, and who will indemnify each party (i.e. each team member and the practice they work in, particularly if they are independent contractors due to payroll tax arrangements).

For example, a GP-led multidisciplinary team caring for a type 2 diabetic patient could typically involve the GP, a registered nurse diabetic educator, a nutritionist, and a podiatrist. Each practitioner has activities that they do within their scope of practice, and they should have clear accountability in that regard. This includes where supervision is required so that those lines of responsibility are clear for each team member at each step:

- The GP determines the type of other professionals who would be useful in the patient's care and monitors the patient clinically in the long term.
- The registered nurse diabetic educator educates and supports the patient in self-managing their diabetes, including thorough guidance on regular monitoring of blood glucose and safe medication management. With an enhancement to their scope of practice, they may also be performing tasks such as referring for HbA1c tests, interpreting those results, providing repeat prescriptions, and adjusting medication.
- The nutritionist assesses the patient's diet and provides advice. With an enhancement to their scope of practice, they may also be able to refer patients for blood tests.
- The podiatrist provides the patient with toenail and foot skin care. With an enhancement to their scope of practice, they may be able to refer a patient for a lower limb arterial duplex scan if they detect that a foot pulse has been lost.
- Each practitioner is accountable for the patient care they provide, including any adverse outcomes, but is not accountable for determining whether the healthcare by other practitioners is being provided at a reasonable standard. So, for the examples listed above, where practitioners in a multidisciplinary team make their own clinical decisions:
    - If the registered nurse diabetic educator decided to substitute a medication for another that was contraindicated, and the patient had an adverse reaction, it would be that practitioner who had medicolegal responsibility for their actions. The GP

who determined the patient should see the registered nurse diabetic educator would not be liable for the actions of the practitioner who made the decision.
    - If the nutritionist provided advice that was not consistent with a reasonable diabetic diet, they would have sole medicolegal responsibility for the outcomes of those decisions. A GP cannot be expected to provide oversight to the extent where they are making judgements about the care provided by other health practitioners.
    - If the podiatrist received an arterial duplex scan result showing an arterial obstruction and did not ensure the patient was referred back to the GP, that podiatrist would have sole medicolegal responsibility for that action.
- When another practitioner orders a test, that practitioner is responsible for ensuring that the result is acted upon and the patient is followed up. Unless delegation or combined responsibility has specifically been agreed to by the other practitioner, it is not appropriate or practical for a GP to carry responsibility where they are purely copied in as a recipient of results and have not directly been involved in the decision to request the test.

As we have said previously, it is integral that indemnity arrangements be designed before new models of care are implemented so that practitioners have cover for the care they provide, and any indemnity questions can be appropriately addressed should they arise. These arrangements should contemplate that multidisciplinary teams may involve multiple employers. Indemnity arrangements would also support clinical governance arrangements.

We strongly recommend that professional indemnity arrangements are recognised by the Review as an essential design consideration in its proposed reforms for multidisciplinary teams and health practitioners working to their full scope of practice in primary care.

Q. Are there additional considerations which have not been raised that could progress the intent of this Review?

No response provided.

Avant Mutual
24 May 2024