Allied Health Professions Australia

Unleashing the Potential of our Health Workforce – Scope of Practice Review

October 2023

This submission has been developed in consultation with AHPA's allied health association members.

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
www.ahpa.com.au
office@ahpa.com.au

Introduction

Allied Health Professions Australia (AHPA) is a collegiate body consisting of 27 national allied health associations members and a further 13 affiliate members. AHPA collectively represents some 150,000+ allied health professionals who provide services across a range of health settings, as well as disability, aged care, education, justice, community services and more in Australia.

AHPA works to provide national leadership that shapes and supports the contribution made by allied health professionals to national health and wellbeing. As the peak national organisation for allied health professions, AHPA has an important strategic leadership role and is the body that Government and other national organisations turn to when they seek a collective view of allied health.

Allied Health Professions Australia (AHPA) welcomes the independent scope of practice review and thanks the review team for the opportunity to provide input on behalf of Australia's allied health professions. This response has been developed in collaboration with AHPA's 27 allied health association members and on behalf of Australia's 200,000 allied health practitioners. We look forward to supporting the four phases of the review process, in particular the development of a fit for purpose implementation plan that will support improved access to care for consumers through an expanded role for allied health practitioners. We note that the AHPA submission focuses on structural issues and that this response should be read in conjunction with the more detailed, profession-specific responses of our member organisations.

This review provides an opportunity for genuine primary care reform, focused on allowing allied health practitioners to work to their full scope of practice in a system that recognizes their role and expertise through appropriate funding and the ability to assess, diagnose, refer and support Australian health consumers.

We welcome the focus in the Terms of Reference for the review to identify and support the role of allied health practitioners: *The role of non-medical clinicians working in primary care will be considered in detail, to identify clinical tasks that could be delivered by the range of clinicians working in primary care to increase patient access and maintain safe quality services. (See: https://consultations.health.gov.au/pccd-communication/scope-of-practice-review/).*

The Strengthening Medicare report also recommended that the Australian Government *'ensure new funding models do not disadvantage people who live in communities with little or no access to regular GP care, and whose care is led by other healthcare providers.' (p5, https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf).*

Allied health professionals can, and do lead care, but full scope practice is limited by current funding. This Review should seek not to disadvantage the consumers relying on patient pathways led by allied health practitioners.

Achieving reforms will provide rapid and significant benefits to consumers, health practitioners, funders of health services, and Australian governments who bear the productivity and welfare costs of care avoidance, failures to prevent adverse health outcomes, and poor support for chronic and complex conditions in the community. Removing gatekeeping functions from medical practitioners will provide some of the most significant benefits, by improving their capacity to focus on high value care, improving the timeliness and accessibility of health services and reducing an unnecessary drain on the public health purse.

Given the ongoing workforce supply issues impacting access to medical services, reducing bottom of scope work by empowering the allied health workforce represents a critical opportunity to improve outcomes across the primary, secondary and tertiary care systems.

1. Who can benefit from health professionals working to their full scope of practice?

For **consumers**, the benefits are clear:

- Accessible services - medical professions, all of whom are subject to workforce supply issues, focus on top of scope, high-value care rather than low value gatekeeping services or services that could be delivered by other profession such as allied health practitioners and nurses. This reduces delays for services that impact access to both private and public medical specialists.
- More timely and affordable services - if allied health and other professions work at full scope practice, funded by governments, and without low value gatekeeping barriers, time, health and financial costs are reduced as consumers can directly access the most appropriate service, such as a musculoskeletal or mental health service, and be directly referred to other appropriate diagnostic or secondary and tertiary medical services as well as other allied health services.

For **health practitioners** allowing top of scope is likely to:

- Reduce churn in allied health professions who can participate in more rewarding work and perceive that their role reflects the clinical diversity of their training rather than involving a narrow and unrewarding range of clinical practice.
- Support professional growth within allied health and medical professions. Where practitioners can regularly work at the top of their scope, they are more likely to develop more advanced skills and expertise that can lead to innovation and development of practice in a way that supports improved patient outcomes.
- Increase quality of life and work/life balance for medical practitioners and specialists who are often working longer hours than desired because they are providing services and supports that could be provided by allied health professions.

For **funders**, a system that supports all practitioners to work at full scope will provide:

- Better value for money, based on the most appropriate provider providing the service, including assessment, diagnosis, referral, and treatment. Currently, our system often funds more expensive secondary or tertiary services because of lack of funded primary care options.
- Reduced expenditure on low or no value care gatekeeping funding barriers, which though intended to constrain costs, result in more expensive services. A person may see a GP multiple times without gaining clinical benefit, particularly where the GP is only providing a required referral.
- More timely provision of services to consumers which may reduce downstream costs resulting from delays in access to services. For example, if a client experiences additional time delays waiting for referral to additional tests, and then potentially to a medical specialist or other allied health service, and this results in a worsening of their health condition.
- A reduction in care avoidance or inappropriate care resulting from higher costs of services/unsubsidized services where a funding system is not funding the most appropriate service, in turn reducing preventable adverse outcomes.

All Australian governments can benefit from a health system that works effectively to minimize morbidity and mortality by engaging all practitioners in consumer care. By improving access to appropriate allied health services, fewer consumers are likely to experience negative health outcomes that can be disabling, reduce productivity, and cause dependence on social and welfare supports. Determining whether care is appropriate is better managed by informed consumers, appropriate funding system safeguards as exist in other funding schemes with direct access such as private health insurance, and regulatory mechanisms than gatekeeping functions that increase costs and reduce medical workforce capacity.

2. References and links to literature or other evidence

Importance of allied health team care, improving access, importance of allied health support for general practice. *'Improving access to allied health professionals through the Champlain BASE™ eConsult service: a cross-sectional study in Canada.'* From: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5647919/

Cost benefit of direct access, mental health system inefficiencies and access barriers. McKell Report 2023 *'Under Pressure – Australia's Mental Health Emergency'*. From: https://mckellinstitute.org.au/research/reports/under-pressure-australias-mental-health-emergency/.

Costs benefits across key conditions for Australian consumers and health system funders. 'Value of physiotherapy in Australia'. From: https://mckellinstitute.org.au/research/reports/under-pressure-australias-mental-health-emergency/. From: https://australian.physio/sites/default/files/Report_FA_WEB.pdf.

Direct access to musculoskeletal care. *'Cost-Effectiveness and Outcomes of Direct Access to Physical Therapy for Musculoskeletal Disorders Compared to Physician-First Access in the United States: Systematic Review and Meta-Analysis*.' From: https://pubmed.ncbi.nlm.nih.gov/33245117/

McPherson, M., Carroll, M. & Stewart, S. Patient-perceived and practitioner-perceived barriers to accessing foot care services for people with diabetes mellitus: a systematic literature review. *J Foot Ankle Res* 15, 92 (2022). https://doi-org.ezproxy.newcastle.edu.au/10.1186/s13047-022-00597-6

Direct access to hearing services and consumer barriers associated with medical referral requirements. 'Report of the Independent Review of the Hearing Services Program. From: https://www.health.gov.au/resources/publications/report-of-the-independent-review-of-the-hearing-services-program?language=en.

Audiology (Ireland) ENT replacement with audiology: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9439272/.

3. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?

Key arguments: The allied health sector is a safe, low risk essential component of the health system as evidenced by the low rate of complaints and sanctions in the Ahpra registered professions and the Australian government's ongoing reliance on self-regulation for a significant proportion of professions. Self-regulation systems are increasingly robust, aided by the work of NASRHP, but are limited by the lack of title protection and requirement for practitioners to participate in self-regulation schemes unless mandated by employers or funding scheme requirements.

Full or extended scope practice provides significant opportunities for Australia's primary care system. If allied health professionals are supported to work at full scope, medical professionals will have increased capacity to address complex medical needs, there will be increased opportunities to safely integrate support roles such as allied health assistants, and consumers will have increased choice at a more reasonable cost. However, without the right structures in place to ensure consistent training standards and quality, to regulate inappropriate care, and to ensure appropriate clinical governance processes are in place, additional risks may arise for consumers.

Depending on how allied health is defined, between 8 and 10 allied health professions are regulated under the National Registration and Accreditation Scheme (NRAS). National Boards play a vital role, ensuring standards associated with initial and ongoing training apply to all practitioners. They define scopes of practice, provide regulatory oversight, and play a role in credentialling some areas of extended practice.

More than half of the allied health professions sit outside NRAS, largely due to their low level of risk to consumers. These regulatory and quality activities largely align with those of the NRAS professions and are further supported by the work of the National Association of Self-Regulating Health Professions (NASRHP). Those mechanisms provide important protections for consumers and

an important support for the ongoing development of the profession. Most government funding schemes and health insurers have recognized those regulatory programs, requiring practitioners to achieve accreditation with their profession in order to provide rebated services.

Consistent registration and accreditation requirements

Self-regulating allied health professions invest heavily in their regulatory and accreditation role and have established structures that are highly effective as a means of protecting Australian consumers. Yet the absence of national laws requiring practitioners from self-regulating professions to be accredited and regulated by their professional bodies and the lack of title protection under the national law, means that allied health practitioners may not always require accreditation. In some cases, it may mean that health practitioners misrepresent themselves.
This has resulted in the need to develop further legislation, in the form of individual state and territory implementations of the National Code of Conduct for unregistered health professionals. While this legislation seeks to address inappropriate care, it does not address the lack of a formal, nationally consistent scope of practice for those practitioners. Instead, individual employers such as hospitals and health services, or individual practitioners are responsible for defining scope and setting quality standards associated with them. This carries risks of variation in scope and, where practitioners are not subject to ongoing CPD requirements, the risk that practitioners don't maintain competence in all areas.

Risk associated with allied health practitioners from self-regulating professions remains well-managed, even without accreditation. The impact of varying accreditation requirements and differing scopes should be considered when seeking to enable full scope practice. National consistency in understanding and defining scope is an important foundation for enabling the allied health workforce to work to their top of scope. AHPA argues that to achieve this, all Australian governments need to recognise NASRHP alongside the NRAS, legislate title protection, and ensure that all self-regulating allied health professionals providing health services require accreditation before they can work clinically in order to align with their NRAS colleagues.

Risks associated with professions that don't have training and quality standards

While the professional bodies comprising the allied health sector have created structures to address the lack of registration under the NRAS, a number of non-allied health professions have not yet developed consistent initial training requirements, accreditation processes, and quality standards. This means that scopes of practice and competencies vary widely. This in turn acts as a barrier to appropriate health system planning and necessitates other support structures including clinical governance processes to ensure appropriate safety and quality for consumers.

Allied health assistants are an important support for allied health professionals and a means of increasing capacity. However, training requirements vary significantly, and scopes of practice can vary widely. Addressing this will require a range of approaches but foremost among those is the need to develop and adopt nationally consistent supervision and delegation requirements. While some funders and employers recognize that allied health assistants may require oversight and delegation from an allied health practitioner, this is not formally embedded in an agreed national

scope of practice and instead depends on the scheme and setting and any funding rules or clinical guidelines associated with those.

The role of credentialling

One of the challenges in enabling full scope practice is that different professions define scopes of practice differently. Some provide highly prescriptive scopes of practice, others provide a framework for personal scopes of practice alongside entry-level or general competency standards, while others still offer formally structured pathways to expand the practitioner's scope of practice.

Regardless of the approach taken, individual professions recognize that individual practitioners gather experience and expertise through their clinical practice and by undertaking formal training. This in turn impacts their scope of practice, providing the potential for extended and advanced areas of practice. Any discussion relating to enabling full scope practice should seek to identify established areas of extended or advanced practice, to determine areas where extended or advanced practice is required, and to provide a framework for a more consistent national approach to requiring and recognizing extended and advanced practice.

4. Evidence and literature references

Victorian AHA Workforce Project: https://vicahaworkforceproject.monashhealth.org/wp-content/uploads/2023/01/3-04-VET-Victorian-Allied-Health-Assistant-Workforce-Recommendations-Overview-v2.pdf.

Exploring utilisation of the allied health assistant workforce in the Victorian health, aged care and disability sectors. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-07171-z.

5. Identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

Key arguments: Health professions work in a wide range of multidisciplinary models, including formal arrangements and in less formal arrangements where they work alongside allied health and medical colleagues. Importantly, full scope multidisciplinary practice is most often alongside specialists and may not involve general practice.
Full scope multidisciplinary care is underpinned by access to interdisciplinary referral, referral for relevant diagnostic imaging or pathology, ability to initiate and participate in case conferencing, ability to access and share relevant patient health and care planning information, and

AHPA welcomes the focus on multidisciplinary care, noting that a wide range of allied health professions currently work in multidisciplinary teams, many of which may be informal. Informal multidisciplinary teams are those that involve multiple health practitioners but without formal coordination other than by the consumer.

Multidisciplinary care most often involves medical specialists, allied health practitioners, aboriginal health workers, and GPs. Importantly, effective multidisciplinary care involves a range of models. General practice forms only one part of the primary care system and there are a range of primary care treatment pathways that do not involve a central role for general practice. For example, eye and hearing care pathways may involve little or no involvement from general practice and the allied health practitioner may have a central role in undertaking diagnostic and assessment activities, coordinating treatment and facilitating access to appropriate secondary and tertiary services. Similarly, pathways for eating disorders may be initiated by a GP but equally by a medical specialist and ongoing, highly effective multidisciplinary care may be provided by a team comprising a psychiatrist, a dietitian, and either an occupational therapist, social worker or psychologist. The importance of digital infrastructure and use of the MHR cannot be overstated here, to ensure continuity of care.

Allied health and specialist models can be highly effective as a means of supporting consumer care. Particularly for a consumer with chronic and complex conditions that require ongoing support in the community but also involve periods of secondary and tertiary care. For example, effective models may support allied health delivered musculoskeletal or mental health care in the community, with capacity to access advice and support in relation to prescribing from medical practitioners, and the capacity to refer directly for medical services and supports where needed.

Best practice models often involve single employer structures such as those found in community health services, Aboriginal Community-Controlled Health Organisations (ACCHOs), and in some aged care programs such as the Commonwealth Home Support Program (CHSP) and Short-Term Restorative Care (STRC).
These structures can be highly effective, providing shared accountability and responsibility for outcomes and in-built incentives for allowing the most appropriate practitioner to provide services due to a shared funding model. This model appears to be one that the Commonwealth is seeking to support through general practice-based models where a GP leads coordination of care across an employed group of allied health practitioners and nurses. While this model does exist in some settings and may be appropriate and effective in some areas and for some conditions, it is by no means the only model of multidisciplinary care. It is also one that is subject to greater variance than government policymakers appear to design for, due to the wide range of employment models that apply in general practice settings, and which impact GPs and other health professionals. These different models of employment for GPs and allied health practitioners may have significant impact on the degree to which multidisciplinary practice is enabled in shared settings, how accountability and benefits from good practice impact practitioners, and how systems (both funding and patient management) are implemented.

Even where a general practice-based approach is appropriate and effective, this should be considered only one of the many models that are needed. The diversity of the allied health sector, the number of different professions, and the areas of specialized expertise within individual professions, means that no general practice is ever going to be able to employ all of the allied health professions that might comprise a multidisciplinary team. It is also essential to recognize the shift to private practice among many allied health professions and the potential for supporting

multidisciplinary models that work across multiple independent businesses. This approach provides a foundation for enabling a large existing workforce.

Multidisciplinary models need to recognize the principles that underpin effective and best practice multidisciplinary care. Multidisciplinary team care works when it recognizes:

1. That the most appropriate lead in a multidisciplinary team approach may not be a medical practitioner.
2. That all team members require access to client information, even if they are external to the organization.
3. Case review and/or case conferencing, including with external providers where needed, is essential but initiation of case conferencing needs to be available to all allied health practitioners and medical practitioners under program and/or funding rules.
4. All members of the multidisciplinary team require the ability to refer for additional services within an organization and externally by all team members.
5. Full access to appropriate digital tools, including My Health Record, that support sharing of, and access to, medical and health information, shared care planning, and improved collaboration and coordination among multidisciplinary teams in multiple locations and organisations.

6. Examples and evidence

'Health professionals' experience of implementing and delivering a 'Community Care' programme in metropolitan Melbourne: a qualitative reflexive thematic analysis'. From: https://bmjopen.bmj.com/content/12/7/e062437.abstract.

7. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

Key arguments: Allied health involvement is supported by a wide body of research and practical experience across a multitude of programs and settings in Australia. Many funding programs such as workers and accident compensation schemes, private health insurance, state and territory funded community health models, and the NDIS provide strong support for allied health access and multidisciplinary care. But the primary care sector lags behind other parts of the system providing significant barriers, most often a combination of failing to fund and at appropriate levels, and imposing gatekeeping functions.

Progress on allied health funding is urgently needed after successive reform failures, largely underpinned by issues of culture and representation.

The scope of practice review comes at a critical time. The Labor government has inherited a primary care system that lags behind OECD countries in relation to the affordability and accessibility of our services and the effectiveness of our primary care system (OECD Health at a Glance 2021, from: https://www.oecd.org/australia/health-at-a-glance-Australia-EN.pdf).

The primary care system has been subject to a range of reviews and reforms, commencing with the Medicare Review in 2015. Despite the potential opportunities for reform that each of those review provided, none have meaningfully addressed access issues or improved management of chronic and complex conditions. This is in significant part due to the failure to engage with the needs of a large proportion of primary care health consumers that are reliant on allied health services. While there is a wide evidence base for the role of allied health practitioners in primary and secondary prevention, rehabilitation and reablement, mental health and wellbeing, and support for the management of chronic and complex conditions, the allied health sector has been effectively excluded from primary care reform until now.

For consumers with the capacity to pay privately, full scope allied health services are widely available across the Australian health system. Direct access to the most appropriate services, including any allied health profession, is available as are direct referrals for the most appropriate diagnostic imaging or pathology services. Direct access is also available to many private secondary and tertiary services, as are direct referrals from an allied health practitioner to private medical specialties. Yet any consumer seeking publicly funded services experiences a broad range of well-established barriers to accessing allied health services, particularly in relation to affordability.

The impact of this is that many Australian health consumers do access primary care patient pathways through private health insurance and out of pocket payments. But that depends on the financial capacity to do so. The relative inaccessibility of those services, particularly for those experiencing socioeconomic disadvantage is why Australia falls behind other OECD countries that recognize the need to improve accessibility for services that do not involve general practice, or where general practice is an adjunct.

Culture and representation

This independent review provides an important opportunity for the Commonwealth to look at the culture and structure of the Department of Health and Aged Care, the programs it funds, and how and where it seeks expert input to inform primary care policy development and program delivery. The focus of the Department and across Commonwealth Primary Care structures such as Primary Health Networks (PHNs) is almost exclusively focused on general practice with pharmacy and mental health the only areas of allied health with any meaningful focus. That has impacted the ongoing lack of representation or understanding of allied health and the breadth of primary care, in turn undermining reform activities.

The Department of Health currently has a Chief Medical Advisor, Chief Medical Officer, Deputy Chief Medical Officers, and a Chief Nursing and Midwifery Officer. All hold senior roles within the Department with significant influence over policy and program design, oversee significant programs and program budgets. By way of contrast, the allied health sector has only inconsistently been represented by a Chief Allied Health Officer (CAHO), a role that was either a dual role or one that was structured at a much lower level in the organisational hierarchy. The current departmental organisational chart (as at 16 October 2023) appears to suggest there is no Chief Allied Health

Officer, acting or otherwise. A significant step back after the formal creation by the previous government of a dedicated CAHO role and office.

Similarly, the committees, advisory bodies, and other representative structures responsible for informing the development of departmental primary care policy have been either exclusively medical or dominated by medical practitioners and the allied health sector has regularly been completely excluded or has had to seek ministerial intervention for inclusion. This history is evident in the last 8 years of primary care reform:

- The structure and design of the Medicare Review was such that the allied health sector did not get a dedicated committee structure and instead had time-limited working groups including the general allied health, indigenous and mental health working groups, whose recommendations went through two layers of medical assessment, the General Practice Primary Care Committee to which the working group was suborned, and the Medicare Review Taskforce.
- The Healthcare Homes program advisory committee was exclusively medical despite the role of allied health services in the chronic disease management services that many Healthcare Homes clients should have been referred to.
- The former Health Minister's Expert Advisory Group met without publicly publishing findings and without allied health despite these resulting in the current voluntary enrolment program.
- The former government's primary care 10-year plan committee only included two allied health representatives after significant pressure on the Minister from the allied health sector resulted in the Department extending a late invitation.
- The Strengthening Medicare taskforce included one allied health representative, responsible for representing some 25+ professions and an estimated 250,000 practitioners.

The representative bias in the Department of Health has carried through to the structure of Primary Health Network (PHN) structures whose Boards are dominated by general practice and medical representatives. While allied health representation has improved, it has generally been limited to representation on clinical advisory boards. Given the volume of mental health and primary care funding being managed by the PHNs, and their role in identifying and informing the Commonwealth about local primary care systems and needs, the lack of allied health representation and expertise should be recognised as a major potential barrier to the Commonwealth's ability to undertake primary care program and policy design.

AHPA strongly argues that the Expert Advisory Group (EAG) for this review will need to include broad allied health representation across physical and mental health as well as more specialised areas led by allied health practitioners such as eye and hearing care if the Review is to shift the narrative of primary care reform. While a single GP is likely to be able to provide an expert opinion on general practice matters, a single allied health practitioner from any discipline is not able to provide an expert opinion that addresses the breadth and complexity of the allied health professions working in primary care.

Funding

Funding is the single biggest barrier to full scope practice for allied health primary care services.

The limitations of mental health funding are well-established as are those of the chronic disease program, excluding as it does a range of allied health professions while also imposing annual limits on services and limitations on service duration. These limitations make services out of financial reach for many. The need for primary care funding reform is similarly well established but has failed to engage outside of general practice.

The Healthcare Homes project was based on a strong international evidence base showing the importance of true multidisciplinary care but was hampered by its focus on a general practice-only model. While the allied health sector was intended to be included in phase two of the program, the failure of the GP-only approach led to the program being discontinued. The subsequent shift to a voluntary enrolment model, based on professional bodies representing GPs campaigning for increased GP funding through the former government's Expert Advisory Group and subsequent Primary Care 10-year plan committee, has added significant costs to our health system and additional hurdles for consumers seeking services, without contributing to a more effective system of care or the access barriers identified by consumers and health system experts. The recent work of the Strengthening Medicare Taskforce shows promise but does continue the narrow focus on general practice-based models, with allied health recognized only as a potential member of a multidisciplinary team based in general practice, or as a PHN-commission supplement in the final report. This review provides an urgently needed opportunity for a reset and a recognition that primary care is broader than general practice.

Yet these previous programs may still provide a foundation for much needed funding reform, which is needed in several key areas if it is to support full scope practice:

1. Funding needs to recognise all professions with a scope of practice aligned with primary care needs. For example, while podiatrists are currently covered by the Medicare CDM program, orthotist/prosthetists are not. Yet both have significant overlap of scope in relation to the prevention and management of diabetic foot disease.

2. Funding parameters for existing Medicare items require review to ensure that barriers on interdisciplinary referrals, direct access, referral to secondary and tertiary services, and ability to initiate case conferences are addressed.

Private health insurance is a major source of Commonwealth and consumer health expenditure, and many consumers purchase policies with the aim of improving access to primary allied health services such as musculoskeletal and mental health services. Yet despite the Commonwealth using a range of tax incentives to drive use of private health, there has been little attempt to provide policy direction for the sector and to drive a focus on full scope practice and high value care. This is most evident in relation to the design of ancillary or general treatment funding policies by insurers.

Insurers are free to offer any combination of rebates for any combination of allied health and other services with no connection to key disease burdens or areas of need.

Similarly, the private health chronic disease management program, funded under hospital cover, provides significant opportunities to expand access to full scope allied health multidisciplinary care to reduce downstream hospital and medical costs. It remains underutilised and focused primarily on telephone based coaching services rather than the intended range of allied health services needed to reduce or avoid hospitalisations. Enabling full scope practice for the consumers most needing services will require a careful focus on identifying and addressing structural and legislative barriers.

Research

The allied health sector is directly impacted by limited access to research funding, research support structures and a lack of allied health data gathering. Different levels of access to research funding, and barriers to research arising from lack of dedicated and funded research time (allied health professionals in public systems generally do not have funding for time spent on research activities unlike their medical colleagues), limits on the allied health data collected by funders, governments, and health services including a lack of progress on the AIHW primary care data asset and inclusion of allied health data, limits data. Given that government and other funders rightly focus on evidence when making decisions about scope and funding, recognising the structural disadvantage experienced by the allied health sector will be essential as a support for a healthcare system that continues to evolve.

References:

Lessons from Healthcare Homes Trial: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9328364/.
A local study of costs for private allied health in Australian primary health care: variability and policy implications. *Australian Journal of Primary Health* **17**, 131-134. https://doi-org.ezproxy.newcastle.edu.au/10.1071/PY10029b

Allied heath clinician research pathways: https://ahpworkforce.com/career-pathways/how-important-are-career-pathways-for-allied-health-clinician-researchers/.

8. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

Key argument: the Commonwealth has the means to address a range of key barriers and to enable allied health practitioners to work at full scope.

The previous responses have identified the key issues impacting full scope allied health practise. It is AHPA's view that the Commonwealth government has significant capacity to enable full scope of practice by focusing on the following areas:

Removing gatekeeping functions that limit decision-making and clinical practice within normal scope for allied health practitioners

Gatekeeping roles assigned to GPs and other medical practitioners under many national health funding programs fail to recognize that allied health practitioners are regulated, subject to codes of conduct, and are able, within a standard scope of practice, to refer, take on clients, and initiate case conferencing. Gatekeeping increases costs to the system, delays care and would be better replaced by improved education and guidance by funders for practitioners and fraud protection to avoid low value or inappropriate care. Funding urgently needs to remove artificial barriers that only exist when patients/consumers are not paying privately or accessing services through a more flexible funding program.

Enabling improved and new funding models focused on access to allied health

New funding models for allied health are needed to support full scope practice by all allied health professions operating in primary care but meaningful progress has been not been made. Pilot programs focused on allied health-led models are needed but Medicare and private health insurance reform will need to occur now to address current barriers.

Developing a national workforce strategy for allied health

A national workforce strategy for allied health will provide the means to develop and implement change across governments and sectors in order to enable full scope practice in primary care. Ensuring that medical, nursing and allied health workforce strategies inform one another is the most effective way to ensure that opportunities to address workforce shortages in medical professions don't just involve increasing supply but also consider ways to support full and extended scope practice by allied health professions.

Recognising the need for multiple multidisciplinary and primary care models

Appropriate primary care models include general practice employment models based on GP and practice nurse services with some on-site allied health services, however these models will only suit in some situations. An appropriate policy and funding approach recognises the equal need to support other models including community health-style models that incorporate a genuinely multidisciplinary team model with a range of allied health, nursing and medical practitioners each

with the capacity to work at full scope. It also includes models that support multiple independent private allied health and medical services to work effectively together in settings such as metropolitan environments with large workforces of private services. Importantly, allowing all members of the multidisciplinary care team to work at the top of their scope, having full capacity to undertake assessments, plan care, refer, and deliver treatment within their scope.

Supporting consistent regulatory requirements for health practitioners and consistent application of title protections for all professions with appropriate standards and regulatory frameworks in place.

Where health practitioners are part of self-regulating professions with a regulatory scheme, there should be a consistent requirement for all practising practitioners to be accredited and subject to that regulatory scheme. Title protections should apply nationally. This will ensure employers and consumers can be confident that practitioners are subject to a regulatory framework that outlines clinical scope, applies requirements associated with ongoing professional develop, and means the practitioner can be sanctioned where they are practising inappropriately.

Improved access to patient health information

Allied health practitioners both within the same organization and external to it require the ability to access and share health information, including a broader range of information than simply diagnosis and medications. While the lack of investment in allied health software vendors to develop My Health Record conformance is a key stumbling block for the sector, so too is the medical nature of the design of the documents that underpin the system. New document architectures will be required to support the information that allied health practitioners would share with other allied health practitioners, specialists, and GPs. Access to a broader range of health information provides an important foundation for top of scope work. If practitioners are better able to access a more complete medical history, understand which other practitioners are involved in care, and access relevant diagnostic or pathology information, practitioners can better draw on their clinical skills.

9. Additional comments

To enable full scope practice by allied health, medical, and nursing professionals, we suggest this Review will need to consider the following areas

How to appropriately define primary care, recognizing that different consumer pathways may have different professions providing care or acting as the coordinators of care

For the allied health sector, primary care is better defined as health services available to an individual outside of the tertiary health system and may not only involve first contact but also referrals from the tertiary and secondary sectors. Primary care is not only the treatment of medical conditions but also supporting development, ongoing management of behavioural or mental challenges, support with the functional impacts of illnesses or injury, rehabilitation, and ongoing support for chronic and complex conditions.

How to consistently define scope of practice and the range of standards, credentialling structures, and other factors that define safe and appropriate practice

Health professions have different ways of defining scope of practice and different documents and standards that underpin how practitioners, funders and governments can understand the skills and expertise of health practitioners, and the limits to how they can practice.
An agreed definition of scope of practice in a broad sense would be useful, as would greater standardization of approaches to scope of practice.

For example, requiring entry-level competency standards for all health professions, and course and placement accreditation associated with those, along with the development of standard scopes of practice and formal credentialling structures associated with extended or advanced practice, would improve the capacity of employers, funders, and other clinicians to better understand the scope and skills of health professions, providing the foundation for top of scope clinical practice.

Consideration of the role of individual states and territories in enabling broader scopes of practice, particularly in relation to prescribing rights, and how to scale these up nationally

Several allied health professions have models in individual states and territories under which their scope is expanded into areas such as prescribing of medications, undertaking of assessments and diagnostic activities for accident and compensation and other state and territory funding programs, and running clinics that reduce the burden on specialties with workforce shortages. Due to the nature of state and territory funding, these models apply in public health settings but are often highly translatable to primary care settings.