Royal Australasian
College of Surgeons

12.03.24

250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

Professor Mark Cormack
The Independent Lead Reviewer for the Scope of Practice Review
Australian Department of Health and Aged Care

Email: scopeofpracticereview@health.gov.au

Dear Professor Mark Cormack,

RE: RACS Responses to Unleashing the Potential of our Health Workforce – Scope of Practice Review Issues Paper 1 Public consultation survey

Please find below the Royal Australasian College of Surgeons (RACS) responses to the public consultation survey on the Scope of Practice Review Issues Paper 1.

1. 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.)

RACS notes that the Scope of Practice review and Issues Paper 1 are focussed on primary care settings. From a RACS perspective, this review is of relevance if regulatory changes in primary care have flow on impacts to secondary care, and how rural generalists with extended scope of practice in procedural surgery also work in primary care.

There is such a shortage of GPs in rural areas, that having them doing procedural work only exacerbates the GP shortage further. Processes need to happen whereby the prospect of being a rural generalist/anaesthetist/obstetrician leads to greater attraction of GPs to rural areas, so that they can do work within an extended SOP but without compromising primary care.

There is a limitation in nationally consistent guidelines for determining the full scope of practice and that includes nationally agreed terms and language usage. The role of the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards in defining and setting the guidelines for scope of practice at primary care or specialist level should be considered. Setting appropriate scope of practice is critical and should be embedded into registration framework in some way which it is not currently.

Clinical Services Capability Frameworks are determined by the state jurisdictions to establishes scope of practice limitations based on the facility. There could be opportunity to bring further alignment between jurisdictions.

Medical indemnity is an area that must be clearly defined should errors happen where decisions are not made properly.

RACS notes the pharmacy trials in prescribing for urinary tract infections (UTI) and other conditions is underway at numerous sites. While it is noted that pharmacists are not working to their full scope of practice due to state and territory legislation, it is imperative that there are regulations to ensure there is a formal medical assessment within a collaborative co-ordinated model for the safe prescribing for serious conditions such as UTI. Similarly the best model would be for rural

generalist with extended scope of practice in procedural surgery is to work alongside a FRACS specialist surgeon who can mentor and supervise, or at the minimum, they have a defined link to a FRACS surgeon or to a surgical unit at a public hospital to ensure rural generalists are well supported.

Sometimes extended scopes of practice can be an unregulated or self-regulated practice which requires to be brought under strict regulation. For example, a large number of GPs in Aotearoa New Zealand with advanced skills in surgery acquired in either Aotearoa New Zealand through experience (without qualification) or acquired overseas with overseas qualification that is not recognised in Australia are utilising these skills for many years without proper regulation. Slowly they are being brought under regulation by strict credentialing criteria whereas earlier they used to get credentialed on historical grounds. It could be an emerging issue when this cohort are not allowed to work to their actual scope of practice.

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 [SELECT]
- A little
- Not at all

3) **Please provide any additional comments you have on the risk-based approach to regulation.**

Risk-based approach to regulation in a hospital care setting appears beneficial in rural, regional and remote settings. This should be supported by appropriate funding mechanisms (e.g. access to MBS items). An example of where risk-based regulation could be applied is in the use of appropriately trained registered nurses, perioperative nurse surgical assistants and nurse practitioners as surgical assistants. RACS has previously stated its in-principle support for these non-medical health professionals to assist as surgical assistants.[1] Expanding MBS eligibility to non-medical surgical assistants, with the appropriate training and experience is important to equity for rural patients and rural surgeons' financial sustainability. Specialist surgeons are best placed to determine who can surgically assist with reference on the complexity of the procedure, the assistant's level of competence and available local workforce. While RACS does not have the authority to mandate training requirements and scope of practice of nurses as this responsibility lies with Nursing and Midwifery Board of Australia (NMBA), RACS would welcome the opportunity to play a significant role in developing training, accreditation and credentialing of these surgical assistance programs with funding from government. This could also be applicable for nurses assisting in endoscopy and urological procedures with the specialist nearby.[2]

There are other kinds of extended scope of practice that could be relevant in metropolitan areas. For example, Otolaryngology Head and Neck Surgical (OHNS) members have noted that physiotherapists and audiologists with extended or advanced practice skills can assess patients with vertigo and tinnitus, respectively. These models can provide quicker and cheaper access for patients with these common conditions, start investigation and treatment earlier and divert patients from OHNS clinics, who don't

[1] RACS submission to the Australian Department of Health and Aged Care Medicare Benefits Schedule Review Advisory Committee (MRAC) consultation - Surgical Assistant Working Group Draft Report https://www.surgeons.org/News/Advocacy/MBS-Surgical-Assistant-Draft-Repor

[2] Nurse Endoscopy For Provision Of Colonoscopy Services In Australia Position Statement of The Gastroenterological Society Of Australia April 2021 https://www.gesa.org.au/public/13/files/Education%20%26%20Resources/Position%20Statements/GESA%20POSITION%20STATEMENT%20Nurse%20Endoscopy%2023Apr21(1).pdf

require an OHNS opinion or treatment. Nurses and audiologists can also be trained to safely remove wax and foreign bodies from ears with the microscope.

Training with and working in a team (local or distant) with relevant specialists is best. Appropriate training by the relevant surgical specialty society and/or RACS would ensure that rural generalists, nurses are educated based on a formal curriculum, meet many of the RACS competencies that are required for RACS Fellows, and that those competencies could be evaluated either via exit examinations or more likely workplace assessments to ensure those practicing at an extended scope of practice are safe for the public.

4) **What do you see as the key barriers to consistent and equitable referral authorities between health professions?**

There should be considerations to accommodate more health professionals into the referral networks. This should be in alignment with the reinstatement and accelerated rollout of the referral algorithms that were previously developed, ensuring efficient and appropriate patient referrals for conditions such as back pain.

In some situations, access to Medicare for the consultation or treatment is contingent on receiving a referral to see the specialist. Enabling Medicare billing items for these practitioners to order investigations and make referrals in line with their area of advanced practice skill should allow more patients to access timely secondary care. Furthermore these referral authorities should be able to provide adequate informed financial consent to these patients seeking specialist care.

Another main barrier is the need for 12 monthly referrals for known chronic conditions which can be a poor use of GP resources. Consideration should be given to more prolonged periods of referral for known chronic conditions.

The variable usage of the My Health Record could hinder the accessibility and storage of health information required for referrals between health professionals if the GP is not involved in the patient journey.

2. EMPLOYER PRACTICES AND SETTINGS

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)**

Credentialling staff and committees require clear legislation, regulation and guidance from government and AHPRA and indemnity insurers, to carry out their duty to ensure health practitioners are appropriately qualified and insured to provide safe quality care to patients. In the absence of clear guidance, credentialling committees will tend to default to the standard scope of practice and named professions. Any extended scope of practice needs to be regulated via AHPRA and not left to the determination of local credentialing committees.

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

A collaborative discussion on defining the scope of practice of rural generalists with extended skills in surgery should outline how they can perform limited scope of procedural practice in response to community need and as part of an interdisciplinary team including FRACS surgeons. This should include a system for maintaining connection of rural generalists with extended skills in surgery with FRACS surgeons in hospitals along the referral pathway from the location where the GP practices.

There is potential to develop a nursing workforce with extended skills in outpatient OHNS, plastics, urology, general surgery (such as breast care nurse, stomal therapists), mainly working as practice nurses or clinical nurse specialists under supervision of specialist surgeons either local or remote.

Increasing support for allied health practitioners with advanced practice skills should be considered which include:

- speech pathologists doing endoscopic assessment of voice and swallow,
- physiotherapists with advance practice skills in vertigo/falls and balance, as well as pelvic floor pathology and continence management,
- audiologists with extended practice skills in managing tinnitus, wax impaction, sudden sensorineural hearing loss.

The main barriers are lack of MBS item numbers for services and limitations on ability to order the limited scope of investigations required or to refer on to a specialist, with those requests and referrals recognised by Medicare so that patient receive the rebate.

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?**

Employers should support multidisciplinary care teams by ensuring the policies, procedures and practices remain patient-centred. Jurisdictions can develop policies for accounting for larger surgical services, so that there is a system's level pathway for rural generalists, nurses and allied health professionals to maintain connection to larger units, as well as for example, continuing professional development (CPD) events, multidisciplinary cancer meetings, morbidity mortality and audit meetings. This should be mandatory and funded either by hospitals or ideally by MBS rebates.

Diversity in the health workforce improves patient outcomes. Teams do better than individuals and diverse teams do better than homogenous teams. Professional silos can limit collaboration. Investing in multidisciplinary care team with dedicated funding is key. Interdisciplinary training, skills maintenance, supportive professional networks for peer support can reinforce the effectiveness of multidisciplinary team care. This is particularly vital in rural surgical teams.

Employers can provide training in teams, rather than professional silos, to reinforce the effectiveness of team-based care. Examples include the RACS Safer Australian Surgical Teams, Definitive Surgical Trauma Care, Early Management of Severe Trauma and simulation courses (such as the rural obstetric emergency course).

These concepts are discussed in detail in the RACS Rural Health Equity Strategy foundation paper on Collaborate for Rural.[3]

Employers should ensure medical indemnity is clearly defined.

3. 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 [SELECT]
- ○ Availability of supervision and mentoring [SELECT]
- ○ Quality of training
- ○ Time burden [SELECT]
- ○ Other [SELECT]

[3] Royal Australasian College of Surgeons. (2020). Rural Health Equity Foundation paper on Collaborate for Rural. https://www.surgeons.org/Resources/interest-groups-sections/rural-surgery/activities

2) **If you chose 'other', please provide details.**

In rural areas, where extended scope of practice would have most impact, the money and time required to travel for training and the difficulties with locum/covering staff to cover the absence of a health worker away for training are significant barriers. Programs like the Obstetrics and Gynaecology Education and Training (OGET) project and the Emergency Medicine Education and Training (EMET) Programs, organised by RANZCOG and ACEM respectively, can allow training to come to the rural area to reduce cost/travel/time for local staff. Additionally, if they are busy doing primary care it can be very hard to train to level of competency at an extended scope of practice without reducing patient access to them as GPs.

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 [SELECT]
- 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?**

A consistent approach to professional titles, like the recent legislative changes around use of the title surgeon would be best, with an education campaign and explainer on the AHPRA website, that pops up whenever a person searches for a practitioner. For example, health professionals should state their title/qualifications/extended scope of practice as - Primary qualification (e.g. *physiotherapist/nurse/surgeon/general practitioner*) with advanced practice skills in (e.g. *vestibular/urology/breast surgery/procedural practice*).

Active participation in CPD to maintain skills in that extended scope of practice and affiliate membership to professional clinical bodies (such as specialist medical colleges) would improve the recognition of health professionals' competencies especially in the areas of extended scope of practice.

Interdisciplinary training opportunities like the Safer Surgical Teamwork course and Definitive Surgical Trauma course should continue. Expanding or redesigning other courses to include nurses, anaesthetists, surgeons, and other health professionals should be considered.

4. FUNDING POLICY

(FYI - Funding mechanism categories)	
Fee-for-service	payment for each episode of care.
Block funding	lump sum payment allocated to service provider.
Blended funding	combination of funding streams, such as block/bundled plus fee-for-service
Bundled funding	single payment for all services related to a specific treatment, condition or patient parameter, possibly spanning multiple providers in multiple settings.
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.**

As mentioned in an earlier response, non-medical surgical assistants such as appropriately trained registered nurses, perioperative nurse surgical assistants and nurse practitioners should be eligible to bill for MBS. The same applies for rural generalists doing an operation etc. A fee-for-service model still works best although recognising that over-servicing needs to be monitored and managed.

To expand on the earlier references to allied health professionals in the care of vertigo, tinnitus and sudden hearing loss, here are some examples of tasks that can be considered.

- Enabling general practitioners to order MRI of Internal Auditory Meati for patients presenting with unilateral or asymmetric hearing loss will reduce need to see OHNS surgeon and get diagnosis faster for patients. However a barrier exists as the MRI is not rebatable for this indication when ordered by a GP.
- Enabling physiotherapists to order Medicare rebatable hearing tests, vestibular function tests and MRI brain/internal auditory meati will enable faster, cheaper access to initial assessment, divert many patients into physiotherapy treatment and reduce number waiting to see OHNS surgeon, who could have been treated by physiotherapist.
- Allowing audiologists to order investigations and commence oral corticosteroid for sudden sensorineural hearing loss.
- Funding nurses to remove foreign bodies, wax and do microsuction for otitis externa and to order rebatable audiograms.
- Funding nurses to order Medicare rebatable imaging and blood tests for defined conditions/circumstances.

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? You may select multiple responses.**

- ○ Block funding
- ○ Bundled funding
- ○ Blended funding [SELECT]
- ○ Capitation
- ○ Salary [SELECT]
- ○ Program grants
- ○ Other
- ○ None

If you selected 'other', please provide details.

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

RACS strongly recommends the continual curriculum development, training, supervision, peer support and CPD for rural generalists, nurses and allied health practitioners to develop and maintain advanced practice skills relevant to the nine surgical specialties. RACS can play a significant role in this program development and implementation with funding from government.

Salary could be an alternative funding mechanism to recognise training and supervision provided by specialist surgeons to other health professionals.

Enabling these practitioners to access Medicare item numbers for procedures and investigations relevant to their advanced practice area would also be important. Within public hospitals, salary support

is considered as the best option as it mostly would be required in hospitals so practitioners could be paid a salary for working at their extended scope of practice.

4) **To what extent do you believe alternative funding policy approaches create risks or unintended consequences?**

- To a great extent
- Somewhat [SELECT]
- A little
- Not at all

5) **How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?**

The block funding arrangement has been deficient when dealing with resources for training. Most of RACS' senior Fellows provide pro bono work at their own time and expense when providing supervision to our Trainees and other health professionals, and at a level of uncompensated stress. Equitable funding and support are required to protect the valuable time of staff and to effectively assist them as supervisors in training and education.

The idea of bundled payment models for surgeries have been floating around with government and insurers. Questions have been raised as to how does one bundle payment for better management of patients before and after they leave hospital, and work associated with low value care.

Packages for VMO fee-for-service surgeons should be examined for new models where financial risk is more equitably shared between health service and surgeon. This is so it protects surgeons against total loss of operating income during elective surgery cessation, with ongoing private rooms costs (in some states there are no public outpatient clinics outside urban centres; all care is provided in private practice room), due to budgetary constraints, natural disasters (like the 2019-20 Australian bushfires) and pandemic (COVID-19). RACS would suggest that models should developed where there are dedicated surgical centres within regional hospitals where the beds are quarantined for surgical patients to ensure appropriate management of waiting lists.

5. TECHNOLOGY

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?**

Technology is an important infrastructure that presents opportunities to unite health professionals across distances and decrease costs. This includes:

- enabling remote/virtual supervision and mentoring within multidisciplinary care teams spanning vast distances and over networks
- enabling rapid information sharing (data as a resource, share existing data)
- broadening secondary telehealth which enable video and telephone consultations between the rural/remote health practitioner of any discipline with the patient and a specialist at another site.

The re-introduction of adequately remunerated secondary telehealth or co-consulting (rural doctor/health professional and patient at one end, urban or regional specialist at the other end) would support health professional working to their full scope of practice. These items were removed from MBS within the last two years in a retrograde step. Secondary telehealth reduces the time and cost of the patient travelling to the urban specialist and vice versa.[4] It enables the rural health practitioner to

[4] Wiadji E, Mackenzie L, Reeder P, Gani JS, Ahmadi S, Carroll R, Smith S, Frydenberg M, O'Neill CJ. Patient perceptions of surgical telehealth consultations during the COVID 19 pandemic in Australia: Lessons for future implementation. ANZ J Surg. 2021 Sep;91(9):1662-1667. doi: 10.1111/ans.17020. Epub 2021 Jun 21.

undertake the physical examination under the direction/guidance of the urban specialist, thereby removing the largest barrier to surgeons using telehealth for rural patients, enables the specialist to convey information to patient and health practitioner at the same time, enhancing both their understanding and contributing to peer to peer learning. There should be funding for any telehealth where a practitioner working an extended scope of practice contacts the "supervising" FRACS surgeon for assistance and help.

Although synchronous video telehealth is preferable, many patients and practitioners use phone telehealth for several reasons, including inadequate internet access and speeds to allow video. Ensuring rural/remote patients have ongoing Medicare funding for phone telehealth is important.

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?**

Real-time information sharing should increase the connectivity of multidisciplinary teams especially in rural settings. This could be supported by strengthening privacy and data sharing legislation to ensure access to patient records is seamless, secure and fully consented to. My Health Record if safe and secure would be very helpful so that patient results and records, correspondence was on a portal that all could access.

Free access to secure telehealth platforms for all rural health practitioners of all kinds (for example Coviu, developed by CSIRO and used by most public hospitals) to reduce financial burden of paying subscription fees could help health practitioners work to their full scope of practice.

Increasing Medicare rebates for primary and secondary telehealth for rural patients and ensuring rebates apply for all kind of health practitioners at the patient end including GP, nurse, allied health worker and Aboriginal Health Workers would also support these practitioners to work to their full scope.

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?**

A reliance on clinical decision support software to diagnose and treat conditions can be detrimental as it can take away clinical reasoning, and be impacted by poor data quality and incorrect patient content. Professional skills such as competencies in Collaboration and teamwork, Communication, Cultural competence and cultural safety, Health advocacy, Judgement and clinical decision making, Leadership and management, Professionalism, and Scholarship and teaching, are vitally important in ensuring that patients receive optimal care, and are hard to substitute with software tools.

Another unintended consequence of these technology strategies could be incentivising urban practitioners to provide telehealth, rather than selecting, training and retaining local rural/remote practitioners to provide care close to the patient's home.

If you provide an email address you will be sent a receipt and a link to a PDF copy of your response.

Email address: RACS.advocacy@surgeons.org