

Universities Australia's submission to Issues Paper Two of the Unleashing the Potential of our Health Workforce: Scope of Practice Review

May 2024

Recommendations

- I. Re-title reform area 1 to **Workforce design, *education*, development and planning**.
- II. Ensure there is comprehensive consultation with stakeholders, including education providers, in the development and implementation of the national skills and capability framework.
- III. Distinguish within the framework, common competencies that exist across all disciplines, irrespective of specialisation, and those that are only attained after specialisation in primary care.
- IV. Address existing barriers to experiential learning in primary care for health professional students.
- V. Develop a primary care clinical/interprofessional education fund. The fund would support a partnership approach between education and health service providers to build capacity in this shared area of workforce and skills development.

Introduction

Universities Australia (UA) welcomes the opportunity to further engage with the Scope of Practice review. The review recommends ways to maximise health workforce utilisation by enabling health professionals to work to their full scope of practice - a goal UA endorses. Education of pre-registration, new entry and already qualified health professionals is an important pillar in achieving this goal. UA's member universities, together with health services and the professions, play a vital role in providing the relevant education and training for students at all of these career points.

UA has made two previous submissions in line with the iterative nature of the review¹. Issues paper two - to which this submission is a response - provides a consolidation of previous feedback. It includes key findings and emerging directions followed by a number of options for reform in the following three areas:

1. Workforce design, development and planning;
2. Legislation and regulation; and
3. Funding and payment policy.

UA's response is largely concerned with the three following reform options proposed under area 1: *Workforce design, development and planning*, especially the first two:

- I. Development of a National skills and capability framework and matrix;
- II. Development of primary health care capability; and
- III. Early career an ongoing professional development

For reference, full details of the options and implementation plans proposed under each of the three main areas are provided in Appendix 1.

General comment - Area 1: Workforce design, development, planning

We strongly recommend the word "education" be included in the title of this reform area. We propose that the title be changed to "Workforce design, ***education***, development and planning". The importance of

¹ [UA Submission to Issues Paper 1](#); and [UA Initial Submission to the Scope of Practice Review Survey](#)

education has been underlined in the issues paper, particularly within this area for reform, and explicit education-related reform options have been proposed. All have ramifications for those involved in health professions education including students, supervisors, education providers, health practitioners/the professions and patients.

Education throughout the careers of health practitioners is vital, including pre-registration, continuing professional development (CPD) and Interprofessional Education (IPE). Omitting the term “education” from the title of this reform area diminishes its importance at all levels of workforce development - from student to advanced practitioner - and the contribution education can make to the desired reform outcomes. In addition to including “education” in the title of this reform area, as outlined above, we recommend that “education providers” are added to the list of stakeholders impacted by this proposed reform.

Responses to selected consultation questions for Area 1

Q1. Do you believe the combined options for reform [under this area] will address the main policy issues relating to workforce design, development and planning you have observed in primary health care scope of practice?

UA supports, in principle, the development of a national skills and capability framework and matrix (“framework”) across the different health disciplines. We endorse it as a platform on which to build the further reform options. Effectively developed and implemented, the framework would be a foundational tool to enable greater understanding across health professions about their scopes of practice. It would go some way to providing a shared taxonomy across health disciplines and offer a helpful guide for education providers, accrediting bodies, professions, employers and consumers. However, we make the following points about the framework development:

- **Ensure there is comprehensive consultation with stakeholders, including education providers, in the development and implementation of the matrix.** Ongoing consultation with stakeholders, including higher/tertiary education providers, is required to ensure that the framework is fit for purpose, implementable and aligned with curricula.
- **Distinguish within the framework, common competencies that exist across all disciplines, irrespective of primary care specialisation, and those that are only attained after specialisation in primary care.** UA supports the development of a skills framework for professions in the primary care team. However, understanding scope of practice begins in pre-registration education delivered by universities and tertiary education providers. New graduates of entry level courses are generalists whose education and training prepares them to work as beginning practitioners across primary, secondary and tertiary care settings. Specialisation into primary care comes post registration. Learning to work collaboratively across professions, including through IPE, begins in university but is prior to specialisation. For the framework to be useful for all stakeholders, it would be helpful if it distinguished shared competencies across all disciplines at entry level and those that are expected only after more specialised primary care education, training and/or experience has been achieved.
- **Collection of relevant information from non-NRAS professions:** The issues paper suggests sourcing information about scopes of practice/skills and capabilities for new graduates in non-NRAS regulated health professionals from the Tertiary Education Quality and Standards Agency (TEQSA). TEQSA is not required to keep - and is unlikely to have - information about courses to this level of detail ². UA understands that Jobs and Skills Australia (JSA) has recently undertaken a project to gather such information and could potentially be of assistance in this regard.

In relation to reform option two, especially, greater inclusion of primary care in entry-level health curricula; and expansion of related experiential learning opportunities in primary care: university entry-level health professions curricula do already cover primary care. However, education providers in many

² TEQSA is only required to gather information that assures that courses satisfy the Australian Qualifications Framework (AQF) level at which they are delivered.

disciplines encounter barriers to experiential learning in this setting. This limits the extent to which students' theoretical knowledge about primary care can be grounded in practice. **We recommend addressing these barriers to expand opportunities for multidisciplinary student learning in primary care.** A list of barriers and suggested ways to address them is provided in Box 1 below.

Box 1: Barriers to experiential learning in primary care for health professional students and suggested ways to address them

Barriers:

- Lack of sufficient, quality clinical placement and/or supervisory capacity.
- Costs to universities of placing students in these settings.
- Some professional accreditation standards which stipulate that supervisors must be from the same discipline as the student. This reduces placement opportunities and constrains IPE.
- MBS and/or other service payment rules³ that limit student experiences in primary care to observation only. This decreases the richness of the learning experience.

Suggestions for addressing barriers:

- Support and/or incentivise primary care providers to work collaboratively with higher education providers on placement models that work for all and build practitioner's supervisory capacity.
- Implement relevant funding rule changes to the MBS and NDIS to allow individual practitioners to claim for supervised student-delivered patient services.
- Support greater IPE by developing ways to enable access and connection to a broader range of disciplines in primary care.
- Instigate changes to professional accreditation standards to support cross-disciplinary supervision.

The issues paper also proposes a range of actions for education providers to amplify students' primary care capability (see Appendix 2 for details). Education providers currently undertake a number of these activities. Even so, amplification of the proposed activities takes dedicated time from all parties to establish relationships and develop, trial and adapt effective supervisory models that work for all involved. **We recommend the development of a primary care clinical/interprofessional education fund to support a partnership approach to this shared area of workforce and skills development.**

In relation to reform option 3 under workforce design, *Early career and ongoing professional development*: Most of this is out of scope for UA. However, knowledge of own scope of practice and developing an understanding of that of other health professionals begins in pre-entry education/training. Education providers, including universities also have a role in upskilling existing professionals. It will therefore be important for health services and universities to continue to work closely together to support transitions from university and to ensure consistency of learning across the two sectors. Mechanisms for optimising this collaboration, as outlined elsewhere in this submission, are encouraged.

Q2: To what extent do you believe these policy options will help to drive the policy intent of the Review in supporting multidisciplinary care teams to work together to full scope of practice?

The proposed policy options are well considered. Effectively implemented they are likely to make a difference through greater understanding of and trust between different professional disciplines. However, unless structural and funding barriers to placement access, supervision and multiprofessional learning in primary care are addressed, they are unlikely to succeed.

Q3: Are there implementation options which have not been considered which could progress the policy intent of these options for reform?

³ In many instances, if students deliver a supervised service to a patient, the primary care practitioner cannot charge an MBS item or NDIS service fee. This prevents pre-registration students from gaining crucial hands-on experience in primary care settings and diminishes the learning opportunity.

UA broadly supports the proposed implementation options. An additional consideration could be to link the framework to the proposed National Skills Passport (NSP)⁴ or similar mechanism. Linking the framework with such a mechanism could provide it with a quality assurance dimension which might otherwise be missing.

Q4: Based on your experience, what features should a skills and capability framework have to ensure it is useful in practice?

It should be a current (“living”), easy to use tool that clearly demonstrates benefits with a low effort to high reward ratio. Benefits would ideally be demonstrated through:

- hands on training/experience of the framework - to build familiarisation with and confidence in its use; and potentially
- promotion through peer accepted champions who can talk to their own use of the tool and the workforce/service benefits it has brought.

Q5: How should the framework be implemented to ensure it is well-utilised?

The proposed suggestions to publicise and promote the framework as an initial implementation step are supported. UA would be willing to help distribute information to our higher education provider members through relevant networks.

In addition, we suggest that active demonstrations of the framework in use are made available to all stakeholders as part of its promotion and uptake. This could take several forms including:

- electing initial pilot sites to demonstrate the framework in action and learn where further refinements may be needed;
- providing online “live”/interactive training options on use of the framework; and/or
- demonstrating success in application, either through case studies or as part of framework training.

Q6: What do you see as the areas where the framework will have the greatest impact on scope of practice?

From an education provider perspective: students would be more inclined to pursue primary care as a career if the framework enables more/quality experiential learning opportunities, cross-disciplinary supervision and IPE in this service setting⁵.

Q7: How do you see the recognition of common capabilities and skills in the framework contributing to the delivery of primary care?

We anticipate that recognition of common capabilities and the ability for health professionals to work to full scope will have the following benefits:

- on health services: greater workforce flexibility and, potentially, capacity;
- on consumers: access to a greater range of practitioners with the relevant skills; and enhanced opportunities for multidisciplinary care;
- on health professionals: increased work satisfaction as a result of greater use of their full skill set and more options for team working/support;
- on education stakeholders: opportunities for enhanced primary care/IPE learning experiences for students/health practitioners.

Other comments:

Our response to this review has focused on Area 1, Workforce design, development and planning. This area is most directly related to education providers such as universities. The other reform areas (*Legislation and regulation; and Funding and payment policy*) are largely out of scope for UA. However, co-dependencies amongst the reform areas suggest that implementation of area 1 will only be successful if the other reform areas are progressed, as outlined elsewhere in this submission.

⁴ The National Skills Passport (NSP) is still under consideration. It aims to support both employers and employees by providing a centralised point of verified skills, experience and qualifications.

⁵ There is a body of well-established evidence showing the link between quality experiential learning and workforce outcomes.

Appendix 1: Issues paper proposed areas of reform and their related reform options

- 1. Workforce design, development and planning:**
 - 1.1 Development of a National skills and capability framework and matrix;
 - 1.2 Development of primary health care capability; and
 - 1.3 Early career an ongoing professional development

- 2. Legislation and regulation:**
 - 2.1 Risk-based approach to regulating scope of practice to complement protection of title approach;
 - 2.2 Independent, evidence-based assessment of innovation and change in health workforce models; and
 - 2.3 Harmonised drugs and poisons regulation to support a dynamic health system

- 3. Funding and payment policy:**
 - 3.1 Funding and payment models incentivise multidisciplinary care teams working to full scope of practice; and
 - 3.2 Direct referral pathways supported by technology.

Appendix 2: Issues paper proposed actions for education providers to support greater inclusion of primary care in curricula

- Defining primary care learning objectives for the curriculum
- Identifying and facilitating opportunities for quality primary care learning experiences
- Actively including consumer input into the design and development of curricula focused specifically on developing skills to support optimal patient-centred collaborative care.
- Establishing a team of appropriately trained supervisors to support SPT.
- Leading curricular changes in support of improving the preparation of learners for practice in primary care, including the inclusion and/or enhancement of IPE content.