We're only using a fraction of health workers' skills—this needs to change

April 23 2024, by Stephen Duckett

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Roles of health professionals are still unfortunately often stuck in the past. That is, before the shift of education of nurses and other health professionals into universities in the 1980s. So many are still not working

to their full scope of practice.

There has been some expansion of roles in recent years—including pharmacists prescribing (under limited circumstances) and administering a wider range of vaccinations.

But the recently released paper from an independent Commonwealth review on health workers' "scope of practice" identifies the myriad of barriers preventing Australians from fully benefiting from health professionals' skills.

These include workforce design (who does what, where and how roles interact), legislation and regulation (which often differs according to jurisdiction), and how health workers are funded and paid.

There is no simple quick fix for this type of reform. But we now have a sensible pathway to improve access to care, using all health professionals appropriately.

A new vision for general practice

I recently had a COVID booster. To do this, I logged onto my general practice's website, answered the question about what I wanted, booked an appointment with the practice nurse that afternoon, got jabbed, was bulk-billed, sat down for a while, and then went home. Nothing remarkable at all about that.

But that interaction required a host of facilitating factors. The Victorian government regulates whether nurses can provide vaccinations, and what additional training the nurse requires. The Commonwealth government has allowed the practice to be paid by Medicare for the nurse's work. The venture capitalist practice owner has done the sums and decided allocating a room to a practice nurse is economically rational.

The future of primary care is one involving more use of the range of health professionals, in addition to GPs.

It would be good if my general practice also had a physiotherapist, who I could see if I had back pain without seeing the GP, but there is no Medicare rebate for this. This arrangement would need both health professionals to have access to my health record. There also needs to be trust and good communication between the two when the physio might think the GP needs to be alerted to any issues.

This vision is one of integrated primary care, with health professionals working in a team. The nurse should be able to do more than vaccination and checking vital signs. Do I really need to see the GP every time I need a prescription renewed for my regular medication? This is the nub of the "scope of practice" issue.

How about pharmacists?

An integrated future is not the only future on the table. Pharmacy owners especially have argued that pharmacists should be able to practice independently of GPs, prescribing a limited range of medications and dispensing them.

This will inevitably reduce continuity of care and potentially create risks if the GP is not aware of what other medications a patient is using.

But a greater role for pharmacists has benefits for patients. It is often easier and cheaper for the patient to see a pharmacist, especially as bulk billing rates fall, and this is one of the reasons why independent pharmacist prescribing is gaining traction.

Every five years or so the government negotiates an agreement with the Pharmacy Guild, the organization of pharmacy owners, about how much

pharmacies will be paid for dispensing medications and other services. These agreements are called "Community Pharmacy Agreements." Paying pharmacists independent prescribing may be part of the next agreement, the details of which are currently being negotiated.

GPs don't like competition from this new source, even though there will be plenty of work around for GPs into the foreseeable future. So their organisations highlight the risks of these changes, reopening centuries old turf wars dressed up as concerns about safety and risk.

Who pays for all this?

Funding is at the heart of disputes about scope of practice. As with many policy debates, there is merit on both sides.

Clearly the government must increase its support for comprehensive general practice. Existing funding of fee-for-service medical benefits payments must be redesigned and supplemented by payments that allow practices to engage a range of other health professionals to create health-care teams.

This should be the principal direction of primary care reform, and the final report of the scope of practice review should make that clear. It must focus on the overall goal of better primary care, rather than simply the aspirations of individual health professionals, and working to a professional's full scope of practice in a team, not a professional silo.

In parallel, governments—state and federal—must ensure all health professionals are used to their best of their abilities. It is a waste to have highly educated professionals not using their skills fully. New funding arrangements should facilitate better access to care from all appropriately qualified health professionals.

In the case of prescribing, it is possible to reconcile the aspirations of pharmacists and the concerns of GPs. New arrangements could be that pharmacists can only renew medications if they have agreements with the GP and there is good communication between them. This may be easier in rural and suburban areas, where the pharmacists are better known to the GPs.

The second issues paper points to the complexity of achieving scope of practice reforms. However, it also sets out a sensible path to improve access to care using all health professionals appropriately.

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