



Unleashing the potential of our workforce - Scope of Practice Review (Strengthening Medicare)

Asthma Australia survey response, October 2023

ABOUT ASTHMA AUSTRALIA

Asthma Australia is a for-purpose, consumer organisation that has been improving the lives of people with asthma since 1962. Asthma affects one in nine Australians or 2.7 million people. Asthma is an inflammatory condition of the airways, restricting airflow and can be fatal. There is no cure, but most people with asthma can experience good control.

Our purpose is to help people breathe better so they can live freely. We deliver evidence-based prevention and health strategies to more than half a million people each year.

OUR ONLINE SURVEY RESPONSE

- **Who can benefit from full scope of practice?**

Consumers are the stakeholder group that stand to gain the most from health care professionals (HCP) working to their full scope of practice. Consumers with chronic conditions may experience specific benefits related to better management of their condition compared to consumers experiencing acute illness or injury episodes. People with asthma is an important example, where many of the 2.7 million in Australia experiencing great disadvantage from the limitations within the available workforce to support the ongoing healthcare needs of asthma, which is a lifelong chronic health condition for most people.

The limitations to appropriate care experienced within current health care arrangements include:

1. Only 33% people with asthma have an asthma action plan (ROGS, 2023). An asthma action plan is a self-management resource critically important for people with asthma, which guides their actions in response to a change in their condition. Asthma action plans have the potential to reduce the risk of urgent healthcare use due to an asthma attack (Gibson, 2004). A literature review currently being overseen by Asthma Australia reveals that time, opportunity cost and skills/confidence are some of the reasons for this.
2. Only 10-40% of people use their prescribed preventer medicine at a rate consistent with therapeutic use (Reddel, 2022). Regular inhaled preventer medication is the most important medication intervention in asthma that improves health, reduces risk of asthma attacks, reducing the risk of urgent health care use, and improves quality of life (AAH, 2023).
3. Up to 90% of people with asthma don't use their inhaler correctly (NACA, 2016). Inhaler devices are complex equipment in asthma and quality use of preventative medicine is only achievable when they're used correctly. Unlike almost all other chronic conditions, the prescription of asthma preventer medicines needs to be accompanied by clear device instructions, which is often overlooked in our current health service delivery models (Bosnich-Anticevich, 2022). A similar proportion of HCPs don't know how to teach correct inhaler device technique (Price, 2013).
4. Reliance on short-acting reliever therapy is common among people with asthma, frequent use of which is a risk factor for asthma attacks and death (AAH, 2023). Approximately 60% of SABA purchase at pharmacy is done over the counter (not requiring a prescription), which reflects asthma 'undertreatment' and a missed opportunity for the system to be supporting people with asthma at an important touchpoint in their pathway (Azzi, 2019).

These aspects of current health care for people with asthma contribute to preventable health issues, including daily symptom burden, acute asthma 'attacks' requiring presentations to emergency departments and hospitalisations, and to a sustained rate of annual preventable deaths (AIHW 2021, OECD 2021, Goeman 2013).

Some segments of the population living with asthma face these challenges disproportionately, including (AIHW):

- People living in rural, remote and regional locations
- Aboriginal and Torres Strait Islander people
- People with low incomes.

Various other stakeholders across the health system also stand to benefit from working at full scope of practice:

- Healthcare professionals themselves, by:
 - Working in the full spectrum of their training and competence, which they have invested time and money in achieving. 32% of surveyed primary healthcare nurses said their skills are underused in practice (APNA, 2017)
 - Contributing to improved patient outcomes
 - Participating in a more efficient and effective health system
 - Greater job satisfaction and workforce retention (Gov Aus Prod Commission, 2023).

HCPs also stand to benefit from working at full scope of practice. When responsibility is distributed across the multidisciplinary team working at full scope of practice, each team member is able to spend more time doing the work that they specialise in.

The community in general along with specific population groups stand to gain from HCPs working to full scope of practice, for example:

- Remote and regional communities who have improved access to quality services (Laurant 2018)
- Culturally and linguistically diverse communities who benefit from access to safe and competent care (Gov Aus Prod Commission, 2023)
- Aboriginal and Torres Strait Islander communities in particular (Pearson, 2020).

- **How?**

People living with chronic conditions benefit from a connected system that considers and responds to the range of their needs. This may be known as ‘connected/coordinated care’, or ‘team care arrangement’ both within teams and between teams. In severe asthma, ample evidence supports the role of the multi-disciplinary approach and its effectiveness in treating people with severe asthma (Gibson and McDonald, 2020).

In post-acute care, successes are evident in care coordination models after discharge (Homaira 2022 and Jayaram 2022). In Homaira’s project, safe discharge after an acute hospital episode was supported by the coordination of care by a skilled nurse, who helped patients assimilate their care plans and prepare for their follow up GP appointment, and they extended this to include in home assessments, designed to identify the presence of asthma risk factors and their treatment or mitigation. These models have consistently demonstrated improvement in asthma outcomes and reductions in asthma-related urgent healthcare use.

Jayaram trialled the delivery of nurse-delivered models of post-discharge care and found this model to be effective at improving asthma outcomes as well as reducing the risk of hospital re-presentation.

Effective and person-centred management of chronic disease is often not best achieved within the current model that is based on GP-delivered short episodic consultations. A 2016 Grattan report found that *at best, our primary care system provides only half the recommended care for many chronic conditions.*

Corollary to this, successes have been seen in diabetes management in primary care with the funding of diabetes nurse educators (MBS) and implementation of nurse-led models of diabetes care (Russell 2013).

Non-pharmacological treatment is important in the recommended asthma model of care as described in the Australian Asthma Handbook (NACA, 2023). This primarily involves education which covers:

- Device technique
- Adherence
- Risk identification and management
- Individual behaviour
- Environmental, social and cultural determinants.

When health consumers access care from HCPs operating at full scope of practice, they benefit by:

1. Reduced time and effort in accessing care, reduced expense and reduced waiting times with the potential to improve outcomes.

Where consumers can't access a doctor due to waiting times, cost of consultations, or lack of doctors, other parts of the healthcare team have the potential to provide real, meaningful, high-quality care within current scope.

Health assessments, provision of education, risk assessments, medicines reviews, updating action plans and writing referrals are all crucial roles that the wider health team have the potential to fulfil, in general, and in specific settings.

Access to these service elements and others have the potential to reduce transaction costs for consumers in accessing routine healthcare, when funding is available to do so. Increasing the available workforce increases the availability of health care that is appropriate, sharing demand, utilising available skills, offsetting workforce shortages and increasing availability of services.

When administrative staff are engaged in patient access pathways, important backend work can get completed, and data collected in a standard way, to be best used by the clinical team and make best use of the consumer's time, avoiding duplication.

2. Care that is comprehensive, evidence-informed and personalised to their circumstances towards outcomes that are important to them

Increasing the available allied workforce in order to share care across the relevant disciplines has the potential to guarantee improved delivery of all components of healthcare, from accurate diagnosis, precision treatment, health education, risk management, wellbeing support and coordination of multi-disciplinary services.

Most of the time, the determinants of asthma and other chronic conditions are those factors outside the medical prescription. Primary healthcare teams working to full scope of practice in support of people with chronic conditions are more likely to be equipped to address the full range of health determinants, including the relationship with the health care provider, building trust and establishing continuity. This may contribute to person-centredness where the consumer feels they have a say in the care that's being designed, tailored to the consumer's circumstances.

3. Improvement in care delivery

A range of technologies available to support quality diagnosis and treatment in asthma are currently under-used in primary healthcare delivery. These technologies include:

a. Lung function testing.

Lung function testing is critical in the diagnosis and monitoring of people with asthma yet is done on fewer than 10% of occasions where asthma is diagnosed in Australia (AIHW, 2016). The common and most feasible lung function test in Australia is called spirometry, which, with adequate training, practice and resourcing, can be implemented by a range of staff in primary healthcare. There are other emerging lung function measures that may be suitable for use in primary healthcare, including FeNO (fraction of exhaled nitric oxide) and oscillometry. Staff working to full scope of practice, funded appropriately, and in a system that's integrated to ensure such lung function testing will be meaningful for the consumer, have the potential to get more from these available technologies in asthma.

b. Symptom tracking, symptom diaries, control assessments and adherence monitoring

Tracking, monitoring and adapting treatment advice around symptoms and adherence is a useful strategy for asthma management which may be under-utilised currently due to time constraints and lack of knowledge. HCPs in primary healthcare working to full scope of practice have the potential to resuscitate these approaches and strategies that have potential to support improved asthma management.

• What risks or negative impact might arise from HCPs working to full scope of practice?

Many potential risks could be mitigated related to HCPs working to full scope of practice. However, it may be important to highlight two potential unintended consequences:

1. Lack of continuity and holistic care.

Holistic care may paradoxically be called into question in the scenario where full scope of practice potentially fragments the person accessing healthcare. The distribution of care and responsibility across a care team should not be misinterpreted as delegation of different 'parts' of the person to different 'parts' of the team. Instead, the different parts of the team all have the holistic needs of the person in view and execute their respective role. The role of the multidisciplinary team is effective when the respective specialist within the team executes their role in the holistic context. Historically, General Practitioners have been very effective at person-centred and holistic care but have been unable to maintain this approach at scale within all communities in Australia due to workforce issues.

The diabetes example is an important one in Australia and instructive towards mitigating the aforementioned risk (McGill, 2017). An effective interdisciplinary model of diabetes care is predicated on the meaningful delineation of responsibility across the care team. In the Australian example, diabetes primary health care has seen greater outcomes coming from an evolved model which began with simply available MBS items that served to encourage team care, towards a structured interdisciplinary approach with a clear shared responsibility, across general practice and diabetes educator, connected with endocrinologist, and supported by the self-management program, DESMOND (Black, 2015). This model addresses the risk that shared care is fragmented when not structured, and demonstrates the need for important policy redress to support its implementation.

2. Lack of investment in resources, skills, development, system integration

If not supported, resourced adequately, provided the right training and development to maintain and build skills, and integrated, an expanded role description can lead to dissatisfaction, disengagement and in the worst case, burnout. Lack of training, quality assurance measures, support and resources will also compromise the safety of patients and the achievement of their treatment goals.

HCPs with greater responsibility need to be trained to maintain skills, remunerated appropriately in line with their value, supported by adapted business models and ways of working, and be integrated into the whole system. This is to ensure patients get maximum benefit and face minimum risk, activities are meaningfully contributing to the overall system, and exhaustion and burnout is minimised whilst satisfaction is ensured.

- **Provide best practice examples where this can work**

Asthma Australia delivered a program called GASP, which was a nurse-delivered model of primary healthcare for asthma. It was based on a similar program which has been in place in New Zealand Primary Health Organisations, producing strong, consistent positive results for people with asthma. The GASP model included decision support software and upskilled nurses, who worked in close collaboration with the medical staff to provide comprehensive asthma care.

In Asthma Australia's pilot, people with asthma experienced a reduced rate of flare-ups requiring emergency medical intervention, improved asthma control, 100% attainment of asthma action plans and described great satisfaction with the model of care (Zwar et al, 2018). Systems barriers have been the main obstacle to full implementation of this program, as there is little to no funding available in primary healthcare to support the bandwidth of the practice nurses in general practice in Australia.

Pharmacy-delivered models of care in asthma have also been shown to be effective (Sudeshika et al, 2023). In the Sudeshika real-world study, pharmacists employed in general practice assessed asthma control, issued asthma action plans, recommended medication changes, and provided device use education. The analysis of the study found that people with asthma enjoyed improved asthma control and indicated this model of care acceptable.

Skilled education-focused health professionals have also great potential to support improved health outcomes including person-centredness. The Asthma Australia 1800 ASTHMA telephone-based information and education service has been complementing mainstream healthcare delivery for decades and repeated evaluations of this program has continued to reveal positive results. Both

HCPs and consumers indicated this model has been effective for them. Asthma, like many other complex chronic diseases, relies heavily on the provision of structured education and information resources to consumers, to complement the care provided in primary healthcare, and plug the gaps that can't realistically be addressed in the current primary healthcare asthma model. This best-practice model is guaranteed via the competency-based training and evidence-informed operating frameworks, and benefits from personal delivery which is critical in a heterogeneous disease like asthma. A comprehensive and intelligent, compliant and integrated technology structure is an essential enabler for the delivery of this model. Asthma Australia is currently evolving this model in partnership with the Hunter Medical Research Institute as part of a randomised control trial and looks forward to demonstrating its fit for full scope of practice purpose in the coming years.

- **What barriers to full scope of practice need addressing?**

Wiggins et al (2022) completed a scoping review of the factors that influence scope of practice relevant to nursing/midwifery, pharmacy and physiotherapy and found the following:

- Education
- Competency
- Professional identity
- Role confusion
- Legislation and regulatory policies
- Organisational structures
- Financial factors, and
- Professional and personal factors.

In addition to this list, Asthma Australia has observed the specific barriers of the culture of healthcare delivery, and the difficulty in uptake of digital health in Australia as being important to scope of practice.

- **Culture of rescue vs prevention**

The culture underpinning the dominant mainstream models of primary healthcare delivery has a number of dimensions in regards to how it relates to full scope of practice discourse.

On the one hand, the problems related to good quality asthma care delivery has been characterised 'rescue culture', where the management of the condition is reduced to the management of flare-ups of asthma, in lieu of prevention of these flare-ups, or attention to addressing the factors that contribute to flare-up risk (Woolcock, 2023). Rescue culture is a legacy of the past where effective systemic anti-inflammatory medicines as well as fast acting bronchodilators were the mainstay of treatment. This modus operandus has been outdated for some time but the system settings have not incentivised or supported its resolution or pushed this needed cultural update. If we are to see significant movement to a 'prevention culture' the GP needs the resources and support to deliver on this and the other actors in the person with asthma's journey need to be empowered to improve their role delivery. This would namely apply to the community pharmacist, to identify risk and have capacity to engage people with asthma around their risk taking behaviour where it occurs during over-the-counter access to medicines especially. The digital environment also has a role to play in support of a prevention culture, where at its best it should be enabling patient identification,

aggregating their medicine usage, and integrating data and medical records for optimised collaboration, shared care.

The other culture specific to chronic disease that is important to point out is the 'gate keeper' model of care. Asthma Australia's GASP program was an effective nurse-delivered model of care which derived clinical benefit for patients enrolled in the program. These benefits included reduced risk of flare-ups requiring medical intervention and qualitative analysis revealed that patients appreciate this new model, where they noticed real expertise, attention to personal needs and felt empowered with new knowledge and skills. However, implementation challenges were frequently reported, which pointed to the need for a suitable environment where nurses were could do the required planning, consultation and follow up to be effective. This environment didn't exist for GASP nurses supporting people with asthma because their practice setup was centred around the role of the GP. Corollary to this, in New Zealand, which is where GASP was created, practice nurses are funded specifically to work in respiratory health and so practices are able to adapt their work flows to enable their nurses to deliver this model of care, without sacrificing other priorities in the primary healthcare service.

- **Digital infrastructure**

The limited uptake of My Health Record to support shared care, and effective collaboration is presumed to be a significant obstacle to HCPs working to full scope of practice. The health service team in the 21st century has a real opportunity to work in ways that maximise efficiency, effectiveness and precision in shared care yet predominantly work in a fragmented environment where data and records are not available, or in the control of the consumer, who experiences trauma each time they need to prosecute their case to a new health professional (TACSI 2019).

Interoperability is a major barrier to the potential for digital infrastructure to unleash our health workforce potential and produce meaningful outcomes. Interoperability in healthcare enables a connected healthcare system that shares health information securely, safely and without any special effort. Where the systems fragment, don't relate, and require special effort, they will remain as barriers to full scope of practice.

- **What enablers need to be supported, invested in, created?**

Enablers of full scope of primary healthcare practice include:

- **Investment (APNA 2023)**

- In primary healthcare to ensure relevant positions are attracted to and retained where they are needed to guarantee high quality care. Asthma Australia would like to see the diverse interdisciplinary team for chronic disease management embedded as a minimum standard, and accessible to all communities in Australia
- In career and education pathways for all staff in primary healthcare, including student placements
- In professional development pathways for allied health team including scholarships, grants and bursaries
- Business development support:

- To primary healthcare small businesses to support discovery and definition of ways of working amenable to recruitment and fulfilment of full scope of practice
- **Digital and technology systems (ADHA 2023)**
 - An integrated, intelligent digital health architecture has the potential to bring services to communities as well as support service quality and efficiency in health service delivery models
 - Digital and mobile health technologies have the potential to improve healthcare engagement, improved healthcare self-management and improved health outcomes
 - These factors suggest there is an important role for established allied health roles to interact with digital systems in data analysis, quality control, proactive health management and case management functions, requiring full scope of practice.

- **Additional comments**

Asthma Australia welcomes this inquiry - Unleashing the potential of our workforce - Scope of Practice Review – and would like to highlight a number of related issues:

1. Specific program and public health application

There is great potential for the healthcare workforce, operating at full scope, to be critical during major public health challenges, as we saw with the vaccine administration model at community pharmacy during the COVID-19 pandemic.

More local public health issues benefit from adequately resourced and supported practitioners working at full scope of practice. This may include limiting access to OTC medicines for people with asthma. Short-acting beta agonists (SABA) have been available over the counter in pharmacy for decades and there is increased understanding of the risks of excessive use of this medicine for people with asthma. The community pharmacy has great potential to address potentially harmful self-medication practices with people with asthma, with the right resources and monitoring of dispensing habits, providing education around the risks associated with increased use, discussing alternatives and calling prescribers to discuss the potential of issuing (alternative) prescriptions.

Oral corticosteroid stewardship is another example where full scope of practice could reduce the catastrophic impact excessive cumulative exposure is having on too many people with asthma. At full scope of practice, community pharmacists could have the potential to monitor cumulative use and activate measures to support the consumer to take decisive action to reduce their risk of further exposure. These measures include providing education, resources and tools about OCS exposure, providing structured referral/communication to the prescriber, and reviewing and updating the consumer's inhaler device technique and adherence to their preventer.

2. Aged care

The Royal Commission into Aged Care Quality and Safety revealed that residents of aged care facilities suffer greatly due in part to the business model that results in under-trained personal care attendants/personal assistants/nursing assistants and similar roles being given too much responsibility with too few skills. Asthma Australia acknowledges that the Federal Government has initiated reforms in response to this specific issue in aged care. Asthma prevalence among older people is high and the risk of death from asthma is greater than that for other age groups. It is imperative that people with specific needs with asthma in residential aged care are not exposed to

greater risk because of inappropriate business models, which may be extreme examples of delegating full scope of practice responsibilities.

3. Extended scope of practice

Extended scope of practice may yet be a further mechanism to improve the availability, accessibility, quality and effectiveness of primary healthcare service delivery.

Across many of the allied health workforce, basic and post-basic training provides for a theoretical platform upon which extended scope may be built. Currently, the 'practitioner' model in nursing and the 'advance practice' model in pharmacy are examples of this in practice. These pathways might indeed be fit for purpose and simply need expansion to ensure that these professionals are available in the communities they are most needed.

However, it might also be useful to consider extended scope specific to specific health challenges, in order that professionals who don't seek years of further study, and business who can't afford to allocate significant time and money to such, can invest in specific development opportunities that equip them with the skills and competency to be effective in specific areas. A real example of this is seen in education in Australia, where school staff do specific training to be competent in managing flare-ups of asthma.

Potential examples of this approach might include the role of a practice nurse to complete and implement an asthma action plan, or a community pharmacist providing an alternative reliever device to a customer over the counter. Asthma Australia would strongly recommend appropriate pilot research to demonstrate the effectiveness and safety of extended scope models before they are implemented in real time.

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