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SUBMISSION

AMA submission to Unleashing the potential of our workforce - Scope of Practice Review

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

The AMA supports all health practitioners to work to their full scope of practice and we do not fundamentally oppose the expansion of scope where it is safe, collaborative, appropriate and benefits patients and the health system.

The issue we face right now — and the major challenge for this review — is the determination of what exactly constitutes 'full scope'. The AMA has repeatedly seen declarations that certain tasks are 'within scope' of certain health professions despite a demonstrable lack of training, accreditation, or support by their Board. There are risks to safety and health resourcing if each health professional group can independently expand their own scope of practice outside of established processes and protocols. The AMA does not want to see a situation where non-medical (or even non-surgical) health professionals are performing surgery on brains and spines as in the UK.[1]

As such, the key outcome the AMA seeks from this review is clarification and reaffirmation of the appropriate and safe pathways for expanding scope that put patient and community safety first. Inappropriate 'scope creep' for the purposes of trying to fill service gaps is a major threat to the health of the community.

In terms of risk, the main risk that this review must focus on is patient safety. It is imperative that an outcome of this review is a reorientation of focus to patient safety and outcomes. The AMA has been seriously alarmed by the complete lack of concern regarding the outcomes of the UTI prescribing trial in Queensland. Hundreds of patients required medical treatment after receiving a prescription from a pharmacy, and the AMA Queensland member survey found at least 240 doctors had treated a patient with a misdiagnosis.[2]

Specific to the expansion of prescribing rights, the AMA is very concerned about the risks posed by antimicrobial resistance. Antimicrobial resistance is one of the most serious global public health threats of our century. Documented in almost all regions of the world, antimicrobial resistance now

[1] Michael Searles (8 October 2023). "Non-medical staff operating on brains, spines after 'learning on the job'", *Sydney Morning Hearld.* Retrieved 16/10/2023 from: https://www.theage.com.au/world/europe/non-medical-staff-operating-on-brains-spines-after-learning-on-the-job-20231008-p5eakf.html

[2] AMA Queensland (9 May 2022). Patients suffered during UTI trial. Retrieved 16/10/2023 from: https://www.ama.com.au/qld/news/NQ-surveryFinalReport

considered to be one of the leading global public health threats of the 21st century,[3] with this threat affecting humans, animals, and the environment. Patients infected with resistant microorganisms are less likely to recover with the first antimicrobial therapy prescribed and therefore require second- or third-line antimicrobials and extended treatments, which are more expensive and frequently have serious side effects.

Dysfunctional regulation and poor stewardship of antimicrobial prescriptions is a major risk for antimicrobial resistance. Autonomous non-medical prescribing models may result in overprescribing of medicines, particularly as the body of evidence on collaborative models reveal that non-medical prescribers often initiate and prescribe more drugs and titrate drugs to a higher dose compared to medical prescribers.[4,5,6,7,8,9,10] For example, a study in Canada found that pharmacists with an expanded role prescribed seven times more antibiotics than physicians for urinary tract infections over the same time period (656 antibiotic prescriptions were initiated by pharmacists, compared to 94 prescriptions initiated by physicians).[11] The study hypothesised that the financial conflict of interest could be one of the reasons why there were more prescriptions initiated by the pharmacist, as the pharmacists was reimbursed an assessment fee each time a patient was initiated a prescription, and could also bill a dispensing fee on each prescription.[12] Similar concerns have also been raised about the association between increased trimethoprim use (the antibiotic used to treat urinary tract infections) and antimicrobial resistance in New Zealand, where autonomous pharmacy prescribing occurs.[13,14]

Another major focus should be on the costs or suggested efficiencies associated with expanding scope. Evidence from the United States suggests that programs where non-medical health practitioners work to expanded scope do not deliver cost savings and, indeed, may end up increasing overall costs across the system. This was demonstrated in the United States where non-medically led primary care was found to cost nearly $43 more per patient than care led by a primary care physician.

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[3] World Health Organisation (2014). *Antimicrobial Resistance Global Report on Surveillance*. Retrieved 21/09/2023 from: https://iris.who.int/bitstream/handle/10665/112642/9789241564748_eng.pdf?isAllowed=y&sequence=1

[4] Cohen, L. B., Taveira, T. H., Khatana, S. A. M., Dooley, A. G., Pirraglia, P. A., & Wu, W. C. (2011). Pharmacist-led shared medical appointments for multiple cardiovascular risk reduction in patients with type 2 diabetes. *The Diabetes Educator, 37*(6), 801-812. Doi: 10.1177/0145721711423980

[5] Ansari, M., Shlipak, M. G., Heidenreich, P. A., Van Ostaeyen, D., Pohl, E. C., Browner, W. S., & Massie, B. M. (2003). Improving guideline adherence: a randomized trial evaluating strategies to increase β-blocker use in heart failure. *Circulation, 107*(22), 2799-2804. Doi: 10.1161/01.CIR.0000070952.08969.5B

[6] Taveira, T. H., Friedmann, P. D., Cohen, L. B., Dooley, A. G., Khatana, S. A. M., Pirraglia, P. A., & Wu, W. C. (2010). Pharmacist-led group medical appointment model in type 2 diabetes. *The Diabetes Educator, 36*(1), 109-117. Doi: 10.1177/0145721709352383

[7] Houweling, S. T., Kleefstra, N., Van Hateren, K. J., Kooy, A., Groenier, K. H., Ten Vergert, E., ... & Langerhans Medical Research Group. (2009). Diabetes specialist nurse as main care provider for patients with type 2 diabetes. *Neth J Med, 67*(7), 279-84.

[8] Margolis, K. L., Asche, S. E., Bergdall, A. R., Dehmer, S. P., Groen, S. E., Kadrmas, H. M., ... & Trower, N. K. (2013). Effect of home blood pressure telemonitoring and pharmacist management on blood pressure control: a cluster randomized clinical trial. Jama, 310(1), 46-56. Doi: 10.1001/jama.2013.6549

[9] Magid, D. J., Olson, K. L., Billups, S. J., Wagner, N. M., Lyons, E. E., & Kroner, B. A. (2013). A pharmacist-led, American Heart Association Heart360 Web-enabled home blood pressure monitoring program. *Circulation: Cardiovascular Quality and Outcomes, 6*(2), 157-163. Doi: 10.1161/CIRCOUTCOMES.112.968172

[10] Denver, E. A., Barnard, M., Woolfson, R. G., & Earle, K. A. (2003). Management of uncontrolled hypertension in a nurse-led clinic compared with conventional care for patients with type 2 diabetes. *Diabetes care, 26*(8), 2256-2260. Doi: 10.2337/diacare.26.8.2256

[11] Yeung EYH, Mohammed RSD. (2019). Pharmacists prescribed 7 times more antibiotics than physicians did for query urinary tract infection. *Can Pharm J (Ott)*. 9;152(5):281-282. Doi: 10.1177/1715163519866223.

[12] *Ibid.*

[13] Hendrie, D. (2020, 29 July). *Experts call for end to controversial pharmacy prescribing trial.* Retrieved 22/02/2023 from: https://www1.racgp.org.au/newsgp/clinical/experts-call-for-end-to-controversial-queensland-p

[14] Medsafe (2018). *Classification of Trimethoprim Information paper for the Medicines Classification Committee.* Retrieved 22/02/2023 from: https://www.medsafe.govt.nz/profs/class/Agendas/Agen60/5.3.1-MCC-Information-Paper-Trimethoprim.pdf

This additional cost was a result of inappropriate prescribing, unnecessary referrals to specialists, and unnecessary orders for diagnostic imaging studies.[15]

The AMA remains concerned that pharmacist prescribing in the community pharmacy setting may also cost the system and consumers more as a result of financial conflicts of interest. In this setting the prescriber is responsible for the prescribing and dispensing of a medicine which may lead to overprescribing.[16,17,18,19,20]

The AMA is also concerned that this process may be used as an opportunity so substitute care currently provided by general practitioners (GPs) for what appear, on the surface, to be less expensive alternatives. There is no evidence that this will improve outcomes particularly when such a strategy is pursued outside a collaborative model of primary health care delivery. There is, however, strong evidence that where GPs are well-funded and resourced the health outcomes of individuals and communities under their care are improved, health expenditure savings are generated, health resources are better utilised, and duplication of services and wastage of healthcare funding is minimised.[21,22 ,23 ,24]

The lack of funding and support for general practice over the last decade has largely created the problems faced by the system right now. Many groups often say that they can "do the easy GP work". While there are many GPs who would like to be better supported in their practices — in a multidisciplinary, collaborative healthcare environment — with some of the care they provide, removing the delivery of this care from general practice is moving our health system in the wrong direction. We do not need further fragmentation, we need integration. The Strengthening Medicare Taskforce reached this conclusion and this review must align with the strategic aim of the Taskforce report.

The AMA also cautions that the excuse of medical workforce shortage to avoid following the proper pathways is dangerous and unlikely to address the root problems given the severe workforce shortages across health professions, as demonstrated in this table:

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[15] American Medical Association (2022). *AMA Issue brief: Expanding nurse practitioner scope of practice leads to increased utilization of health care resources*.

[16] Kwon, S. (2003). Pharmaceutical reform and physician strikes in Korea: separation of drug prescribing and dispensing. *Social science & medicine, 57*(3), 529-538. Doi: 10.1016/S0277-9536(02)00378-7

[17] Mak, V., & Hassali, M. A. (2015). Separation of dispensing and prescribing in Malaysia: will the time come?. *Journal of Pharmacy Practice and Research, 45*(4), 394-395. Doi: 10.1002/jppr.1162

[18] Park, S., Soumerai, S. B., Adams, A. S., Finkelstein, J. A., Jang, S., & Ross-Degnan, D. (2005). Antibiotic use following a Korean national policy to prohibit medication dispensing by physicians. *Health policy and planning, 20*(5), 302-309. Doi: 10.1093/heapol/czi033

[19] Harbarth, S., & Oberlander, C. (2004, March). Do health care regulation and physician industry interaction influence antibiotic resistance rates? The example of antimicrobial prescribing and dispensing in Japan. *In International Conference on Improving Use of Medicines. Chang Mai, Thailand: World Health Organization.* Retrieved 23/02/2023 from: https://slideplayer.com/slide/4531569/

[20] Australian Commission on Safety and Quality in Health Care (2022). *Antimicrobial stewardship.* Retrieved 23/08/2022 from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/preventing-and-controlling-infections-standard/antimicrobial-stewardship

[21] Baird, B., Reeve, H., Ross, S., Honeyman, M., Nosa-Ehima, M., Sahib, B., & Omojomolo, D. (2018). Innovative models of general practice. The King's Fund. Retrieved 13/09/2021 from: https://www.kingsfund.org.uk/publications/innovative-models-general-practice.

[22] The Royal Australian College of General Practitioners (2019). Vision for general practice and a sustainable healthcare system. Retrieved 13/09/2021 from: https://www.racgp.org.au/getattachment/e8ad4284-34d3-48ca-825e45d58b2d49da/The-Visionfor-general-practice.aspx

[23] The World Health Organisation (2008). The world health report 2008: primary health care now more than ever. Retrieved 13/09/2021 from: https://www.who.int/whr/2008/whr08_en.pdf

[24] Barker, I., Steventon, A., & Deeny, S. R. (2017). Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. Bmj, 356:j84. Doi: 10.1136/bmj.j84

Medical practitioners, nurses and midwives, and pharmacists as a proportion of Australian population by remoteness, 2021[25,26]

	Major cities	Inner regional	Outer regional	Remote	Very remote
Medical Practitioners	0.5231%	0.0943%	0.0372%	0.0056%	0.0025%
Nurses and Midwives	1.6707%	0.4160%	0.1746%	0.0261%	0.0152%
Pharmacists	0.1426%	0.0261%	0.0108%	0.0015%	0.0006%

Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

The AMA strongly encourages the reviewers to closely scrutinise the suggestions made in this section. A challenge in the public discussion on expanding scope of practice has been the misrepresentation of international models of healthcare. For example, there have been frequent claims in the pharmacy prescribing programs in states and territories that autonomous pharmacist prescribing is a regular occurrence in other similar countries. This is not the case. AMA analysis of international non-medical prescribing models found that the majority of non-medical prescribing occurs as part of multidisciplinary teams, led by medical practitioners, or in collaborative healthcare settings such as general practices and hospitals.[27]

The collaborative models utilised overseas demonstrate that in specific, structured, and collaborative contexts — with appropriate protocols and clinical governance mechanisms in place — collaborative non-medical prescribing models can deliver comparable outcomes to medical prescribing models.

All discussions of the expansion of pharmacist scope of practice in Australia have focused on autonomous prescribing in community pharmacy settings. This is the worst setting for pharmacists to prescribe in, noting that pharmacists already work collaboratively in hospitals, general practices, Aboriginal Community Controlled Health Services (ACCHOs) and aged care facilities. Noting the international evidence, it is in these settings that our attention should be focused.

As demonstrated by the international literature, collaborative non-medical prescribing models can balance improving patient access to medicines, minimise clinician workload, make better use of healthcare professional skills within their scope of practice, and ensure quality use of medicines.

Outside of primary care, a model used in some Victorian hospitals that enables credentialed pharmacists to be more involved in the clinical decision making relating to medicine management offers a positive example. The Partnered Pharmacist Medication Charting model involves pharmacists independently leading the medication reconciliation and charting process and generating a medication plan for admission in consultation with the admitting medical practitioner. Studies

[25] Department of Health and Aged Care (2023). *National Health Workforce Dataset.* Data output: professions, year, remoteness area 2016. Retrieved 24/02/2023 from: https://hwd.health.gov.au/datatool/

[26] Australian Bureau of Statistics (2022). *Population estimates by Significant Urban Area and Remoteness Area 2001 to 2021.* Retrieved 24/02/2023 from: https://www.abs.gov.au/statistics/people/population/regional-population/2021/32180DS0004_2001-21.xlsx

[27] A good summary is found here: Holly Payne (2022). How do pharmacists in other countries prescribe? *The Medical Republic*.

demonstrate this collaborative model improves outcomes for patients and is well received by practitioners. [28,29,30]

Unlike this example, the autonomous pharmacist prescribing models proposed in Australia will fragment care between general practice and the community pharmacy in an ad-hoc basis. All non-medical prescribing should occur collaboratively with medical practitioners to avoid care fragmentation and ensure patient safety, in line with the evidence. Appropriate regulations, clinical governance guidelines, protocols, clinical data sharing mechanisms, and monitoring and evaluation frameworks will also need to be implemented to ensure these models are safe and effective.

There are also positive collaborative models in the hospital system which demonstrate how non-medical health professionals can work to the top of their scope collaboratively to improve patient outcomes and reduce strain on doctors. Hand therapy clinics run in Victoria ensure that only patients requiring review by a surgeon are progressed through to the outpatient clinics, with the hand therapists taking a leading role in the triaging and then management of patients. Hand therapy led clinics in public hospitals, connected with and driven by surgeons, have been run for almost twenty years, and involve hand therapists working at top of scope, managing patients with specific clinical conditions in accordance with evidence-based protocols, supported by medical staff.[31] Similar models have also demonstrated positive results in the UK.[32]

A positive collaborative model that demonstrates multidisciplinary care with all members of the team working to full scope is the Nuka System of Care in Alaska. This model uses elements of the patient-centred medical home model, with multidisciplinary teams (termed 'teamlets') providing integrated services in primary care settings and the community, coordinated with a range of other services.[33,34]

The 'teamlet' consists of four healthcare professionals:

- general practitioner: primarily responsible for the initial assessment and diagnosis, overseeing the development of treatment plans, and advising and reviewing plans when there is a change in conditions
- nurse case manager: triages, coordinates care, supports the development of care plans, monitors against the care plan, and provides education on how to manage conditions
- case management support staff: schedule appointments and build relationships with patients, and also work with nurse case manager on prevention and population health

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[28] Atey, T. M., Peterson, G. M., Salahudeen, M. S., Bereznicki, L. R., Simpson, T., Boland, C. M., ... & Wimmer, B. C. (2023). Impact of Partnered Pharmacist Medication Charting (PPMC) on Medication Discrepancies and Errors: A Pragmatic Evaluation of an Emergency Department-Based Process Redesign. *International Journal of Environmental Research and Public Health, 20*(2), 1452. Doi: 10.3390/ijerph20021452

[29] Tong, E. Y., Mitra, B., Yip, G., Galbraith, K., Dooley, M. J., & PPMC Research Group. (2020). Multi-site evaluation of partnered pharmacist medication charting and in-hospital length of stay. *British journal of clinical pharmacology, 86*(2), 285-290. Doi: 10.1111/bcp.14128

[30] Tong, E. Y., Hua, P. U., Edwards, G., Van Dyk, E., Yip, G., Mitra, B., ... & PPMC Rural Regional Research Group. (2022). Partnered pharmacist medication charting (PPMC) in regional and rural general medical patients. *Australian Journal of Rural Health, 30*(5), 593-600. Doi: 10.1111/ajr.12895

[31] Monash Health – Hand Therapy: https://monashhealth.org/services/allied-health/occupational-therapy/hand-therapy/; Sobb, J.-A., Tharakan, C., & Beazley, J. (2022). Allied health led post-operative hand clinic: Evaluation of an alternative model of care. *Australian Occupational Therapy Journal*, 69(1), 77–88. https://doi.org/10.1111/1440-1630.12771

[32] Wong, J., Chipchase, L., and Gupta, A. (2022) .Agreement between hand therapists and hand surgeons in the management of adults with closed metacarpal fractures. *Musculoskeletal Science and Practice*, 60, https://doi.org/10.1016/j.msksp.2022.102560.

[33] Collins, B. (2015). *Intentional whole health system redesign. Southcentral Foundation's' Nuka'system of care.* London: The King's Fund. Retrieved 03/10/2023 from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/intentional-whole-health-system-redesign-Kings-Fund-November-2015.pdf

[34] Breadon, P., Romanes, D., Fox, L., Bolton, J., & Richardson, L. (2022). *A new Medicare: Strengthening general practice. Grattan Institute.* Retrieved 12/10/2023 from: https://apo.org.au/sites/default/files/resource-files/2022-12/apo-nid321019.pdf

- certified medical assistant: manages the daily schedule, greets patients, sets up examination rooms, and also carry out tests and screenings.[35]

Pharmacists, dieticians, behavioural health consultants, psychiatrists, midwives, and other healthcare professionals are used depending on patient needs. Healthcare professionals work to their top of scope within these teams, for example, pharmacists perform medication reviews, support patients to manage multiple prescriptions, and provide repeat prescriptions.[36]

The Nuka System of Care is widely regarded as a very successful models of care, improving patient outcomes while also reducing pressure on hospitals and general practitioners. [37,38] The Nuka system has led to significant savings which have been reinvested back into other areas.[39]

The AMA is aware of many versions of the multidisciplinary primary care team already functioning in Australia despite the lack of appropriate funding mechanisms. Many ACCHOs have developed their own models tailored to their communities which will invert the traditional model of doctor first for patients requiring multidisciplinary care. For example, a patient with a chronic disease plan will attend the clinic and see practice nurse for assessment, then see the Aboriginal health worker, the practice pharmacist and finally they GP. This allows all members of the team to work with the patient to discuss the patient's health and progress in managing their healthcare issues and allows the GP to focus on the most important aspects.

The AMA is also aware of general practices around Australia that provide nurse-led walk-in services which have structured care pathways and ensure the GP reviews all patients. These usually require an out-of-pocket payment to cover the costs, but they are valued by patients as there are clear escalation protocols where patients are seen in a timely manner. The AMA is happy to arrange for the reviewers to visit a practice to observe these collaborative models of care where practice nurses work to the top of their scope.

What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

While the AMA appreciates the intention of exploring barriers and enablers to working to full scope, it implies that expanding scope of practice is objectively a positive and that we should be working only to expand scope and remove the barriers we have in place. We do not support this.

Barriers, or regulations, exist for a reason. The Australian Health Practitioner Regulation Agency (Ahpra) regulates Australia's health practitioners (in conjunction with the 15 National Boards, state and territory boards and at the direction of the Health Ministers) ensuring a level of protection for the public and providing reassurance that a registered health professional is trained, accredited, insured and appropriately qualified to provide the care they are providing. The AMA has just contributed to a lengthy process to restrict who can perform cosmetic surgery in Australia to achieve just this outcome. This is a positive example of erecting barriers and establishing scope of practice restrictions on certain medical procedures.[40]

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[35] *Ibid.*
[36] *Ibid.*
[37] *Ibid.*
[38] Gottlieb, K. (2013). The Nuka System of Care: improving health through ownership and relationships. *International journal of circumpolar health, 72*(1), 21118. Doi: 10.3402/ijch.v72i0.21118
[39] Collins, B. (2015). *Intentional whole health system redesign. Southcentral Foundation's' Nuka'system of care.*
[40] Ahpra (3 April 2023). Patients better protected under new cosmetic surgery reforms: https://www.ahpra.gov.au/News/2023-04-03-cos-surgery-update.aspx

There are processes, or barriers, that the AMA had assumed were still in place prior to the announcement of the North Queensland Prescribing Pilot that have been all but ignored. The AMA would like to see these processes, detailed below, reestablished and updated.

In 2016 the Australian Health Ministers agreed to introduce a national governance framework and process for non-medical health practitioners to apply to prescribe or expand their prescribing of medicines, and the National Prescribing Competencies Framework.[41]

This agreement by Health Ministers acknowledged the risk to patient safety highlighted in the Health Professionals Prescribing Pathway Project Final Report (HPPP) of 2013.[42] The final report described the ever-increasing ad hoc and inconsistent practices and approaches to education, practitioner competence and prescribing occurring across various non-medical health professions and within various jurisdictions. The primary objective of the HPPP project was to address these critical concerns and it now appears the unilateral actions of state governments will see a return to the turmoil that Ministers had previously sought to address.

The AMA has repeatedly highlighted this process to premiers and health ministers but we are yet to receive a response even indicating an awareness of these processes. We are concerned that the premiers and health ministers who approved these programs do not understand the role, purpose and function National Registration and Accreditation Scheme that they are responsible for.

Moving forward, the AMA would like to see these pathways utilised and strengthened. Processes and pathways to expand scope, not just non-medical prescribing, must be developed with clear frameworks that demonstrate positive results for:

- safety including adverse outcomes
- patient health outcomes
- cost effectiveness
- impact on reducing workload for medical prescribers
- impact on general practices and emergency departments
- impact on Medicare and the Pharmaceutical Benefits Scheme (PBS) Safety Net
- the effectiveness of education, training, and accreditation
- the effectiveness of regulations.

Specific to prescribing, AMA's 10 Minimum Standards for Prescribing were developed to ensure that all non-medical prescribers worked to a basic safety standard. These standards should be incorporated into the processes.

What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

The AMA is strongly of the view that regulators have appropriate tools and processes to amend the scope of practice of specific health professionals, but they are not always being utilised. The process of expanding scope must involve broad consultation including conducting a consultation regulation impact statement, engaging with other National Boards and with all relevant stakeholders. The AMA upholds the consultation process that the Pharmacy Board of Australia undertook in 2018 and 2019 in the development of the Pharmacy prescribing position statement as an example of this.[43]

The Pharmacy Board undertook multiple public consultations, engaged their registrants and other stakeholders, including medical practitioners, in a robust process. The final determination was a

[41] NPS Medicinewise (2021) Prescribing Competencies Framework.
[42] Health Workforce Australia (2013) The Health Professionals Prescribing Pathway.
[43] Pharmacy Board of Australia (2019) Pharmacist prescribing - Position statement.

nuanced position which endorsed structured and collaborative prescribing models, but noted that autonomous prescribing was currently beyond the scope of practice for pharmacists. It also detailed the steps for it to become part of a pharmacist's scope.

The Pharmacy Board's position statement on prescribing states:

> "The Board's view is that autonomous prescribing by pharmacists requires additional regulation via an endorsement for scheduled medicines. This would require the Board to make an application to the Ministerial Council for approval of endorsement for scheduled medicines under section 14 of the National Law and to develop a registration standard for endorsement of registration. An application could only occur after completion of preparatory work to develop a case proposing the need for an endorsement as outlined in the AHPRA Guide. The Board is not making an application for approval of endorsement for scheduled medicines at this time."[44]

In spite of this consultation, the position of the Board, and the Australian Poisons Standard, multiple states and territories have now established autonomous pharmacist prescribing programs.

This is a clear demonstration that the barriers we have are ineffective and require bolstering.

The Nursing and Midwifery Board is currently consulting on the scope of practice for registered nurses. Again, this is an example of our regulators following through with appropriate process. The AMA has engaged with this process and will continue to.[45] It is frustrating when one part of the system is following process while another ignores it, as recently demonstrated by the Queensland Government.

AMA Queensland was alarmed by a proposal from the Queensland Government that would see registered nurses given prescribing rights for MS-2 Step. The AMA was supportive of recent reforms to expand access to the medical abortion medicines, however we noted concerns about the lack of support for prescribers and dispensers, and highlighted these medicine have risks. Expanding access so rapidly and providing prescribing rights which is outside of a registered nurse's scope while the consultation is underway demonstrates how absurd it is to have these processes in place if jurisdictions can ignore them.

The AMA Queensland submission also highlights the concerning attitude towards the Therapeutic Goods Administration (TGA), Australia's medicines regulator who oversees the scheduling of medicines:

> "It is concerning that Queensland Health's proposal includes possible removal of gestational limit requirements on the dubious grounds that 'the gestational limit for use of MS-2 Step is determined by the TGA and could be subject to change'. This is not a sensible or reasonable justification for removing the important safeguard of TGA requirements and must not be progressed."[46]

The issue is not barriers, rather it is the many enablers that state and territory governments have through the composition of the National Law and their own legislation which allows them to pick and choose which regulations, independent advice or processes they can ignore. This has created the current situation where the determination of the TGA on medicine scheduling is completely ignored and health and safety risks to the community can be ignored by health ministers.

The AMA would like to see more consistency from states and territories, specifically in observing the processes of the National Boards and the medicines scheduling decisions of the TGA and the Advisory Committee on Medicines Scheduling (ACMS), as amendments to state and territory regulations

[44] Pharmacy Board of Australia (2019) Pharmacist prescribing - Position statement.
[45] Australian Medical Association (2023) AMA Submission to consultation regulation impact statement: Nursing and midwifery board Registration standard: Endorsement for scheduled medicines — designated registered nurse prescribers.
[46] AMA Queensland (2023). Submission: Proposed amendments to health legislation including medical abortion.

ultimately mean that Schedule 4 medicines (prescription only) can be treated as Schedule 3 medicines (pharmacist only).

A key recent example was the determination to not down schedule the oral contraceptive pill from Schedule 4 to Schedule 3. In its determination, the TGA stated the following in its reasoning for not amending scheduling:

> "...regular reassessment by a medical practitioner allows routine preventive health screening (such as cervical smears, pelvic exams, clinical breast exams and screening for sexually transmitted infections) as well as regular review of the suitability of continued oral contraception compared to other forms of long-acting reversible contraception, which are not available without a prescription. I have weighed the severity and frequency of adverse effects, alongside the seriousness of potential drug-drug and drug-condition interactions without medical practitioner intervention and follow-up against the benefits of increased access. In doing so, I remain of the firm view that medical practitioner involvement is required and the current scheduling of oral contraceptive substances under Schedule 4 remains appropriate."[47]

This determination implies that the TGA relies on Schedule 4 medicines to be prescribed by medical practitioners and contradicts autonomous pharmacy prescribing now in several states and territories.

The AMA still actively engages in the consultations from the ACMS. A notable recent example was the potential up scheduling of modified release paracetamol. While the ultimate decision was not to up schedule, the AMA does wonder whether states and territories would have observed this decision.

A relevant example of why this process is important and effective is the up scheduling of codeine. This was fiercely objected to by pharmacy groups, yet the evidence has demonstrated that this was a sensible regulatory change which effectively changed the scope of both pharmacists and medical practitioners (as well as some non-medical prescribers such as dentists) for the benefit of the community. A review of the impact in Victoria demonstrated that it decreased codeine-related deaths, poisonings, and presentations to emergency departments.[48]

The AMA is uncertain about the ongoing role of the TGA in the current landscape of states and territories picking and choosing how they will use the Poisons Standard. This Standard has served Australia well, ensuring appropriate and safe access to medicines. We genuinely hope that an outcome of this review is an endorsement of the TGA and its role in scheduling medicines.

The AMA does note that there are many areas where health professionals are limited from working to their full scope throughout the health system. For example, many GPs who would like the practice nurse to be able to support them in more of the work they do. The AMA was very supportive of the expansion of the workforce incentive program (WIP), which had been an advocacy priority for the AMA for years.

The AMA is supportive of funding models like the WIP to encourage multidisciplinary care, ideally organised in or around general practices. The introduction of MyMedicare and patient enrolment should be capitalised upon, not undermined by fragmentary models.

Another essential process in the Australian health system is the Medical Services Advisory Committee (MSAC) process. MSAC is an independent non-statutory committee established that evaluates medical services proposed and advises the Government on whether it should be publicly funded. The review

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[47] Therapeutic Goods Administration (2021). Notice of final decisions to amend (or not amend) the current Poisons Standard - ACMS #34, Joint ACMS-ACCS #28, ACCS #31. Available at: https://www.tga.gov.au/sites/default/files/notice-final-decisions-amend-or-not-amend-current-poisons-standard-acms-34-joint-acms-accs-28-accs-31.docx

[48] Bishop, M., Schumann, J.L., Gerostamoulos, D., and Wong, A. (2021). The impact of codeine upscheduling on overdoses, Emergency Department presentations and mortality in Victoria, Australia, *Drug and Alcohol Dependence*, 226, https://doi.org/10.1016/j.drugalcdep.2021.108837.

assesses each proposal on its comparative safety, clinical effectiveness, cost-effectiveness, and total cost, using the best available evidence.

MSAC conducts public consultations on proposals and reports on their recommendations are published online. It is essential that all health services that receive commonwealth funding complete the appropriate MSAC process. The public consultation and review process ensures that the Australian public can be certain the health budget is being spent on services that deliver on health outcomes and deliver value for money.

Please share with the review any additional comments or suggestions in relation to scope of practice.

The AMA has been frustrated by recent changes to scope of practice due to the ad-hoc rollout, lack of evidence and complete disregard for process. The example of autonomous prescribing by community pharmacists which is being introduced by states and territories demonstrates all of the AMA's major concerns.

In this instance, the efforts to expand the scope of practice of pharmacists beyond the scope determined by their National Board has been led by an industry lobby group.

The AMA remains particularly concerned with the following issues raised by the Pharmacy Board in their position statement:

> "Conflicts of interest need to be managed such as the capacity for a service provider to generate additional income by prescribing and supplying the prescribed medicines and/or pharmacists prescribing medicines when treatment by another health practitioner is in the patient's interest...
>
> "Separation of prescribing from the supply of medicines to ensure that an independent check of the prescribing occurs needs to be addressed in the development of any model of pharmacist prescribing."[49]

There are also public health risks, for example the significant risk of antimicrobial resistance spreading through the over-prescription of antibiotics. This is not a small risk, and given the emerging evidence it is irresponsible for any discussions of prescribing to not include specific risk analysis related to antimicrobial resistance. The AMA strongly calls for all future expanded prescribing protocols to include a specific protocol to measure and report on antimicrobial resistance.

Ultimately, this review needs to rebuild the "barriers" so that they are fair and consistent, so that they observe the expert independent guidance of institutions like the TGA, and support collaborative models of care that align with the objectives of the current reforms underway.

The process for approving an expansion of scope and the settings where this can occur must be evidence based, consultative, and appropriately regulated, for example with independent assessment and oversight potentially by someone like the Australian Commission on Safety and Quality in Health Care (ACQSHC), as suggested by the Grattan Institute in their report A new Medicare: Strengthening general practice.

The AMA is open to more trialling of models of expanded scope for some health professionals, working in the GP-led multidisciplinary team. This ensures the best model of clinical governance and risk management. The AMA has discussed a range of models which could be explored including models of pharmacist prescribing within the general practice for enrolled patients to assist with medication management, or trialling an expanded scope for practice nurses within general practice specific to the diagnosis and prescribing for UTIs.

[49] Pharmacy Board of Australia (2019) Pharmacist prescribing - Position statement.

The problem is that we do not have the appropriate structures in place to allow this to occur easily. The barriers to trialling and then expanding successful, multidisciplinary, collaborative models are what we should focus on identifying and removing.