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AMA submission – Proposed registration standards: Endorsement for scheduled medicines for registered nurses prescribing in partnership

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The AMA is pleased to respond to the Nursing and Midwifery Board's proposal to introduce a pathway for registered nurses to train and apply for endorsement to prescribe scheduled medicines under the supervision of an authorised prescriber.

In summary, the AMA cannot support the proposal as it currently stands. The reasons for this are described below in detail. Many of the points made below were raised in the AMA's submission of December 2017 responding to the Board's earlier discussion paper, and are repeated here again as the current consultation paper has not adequately dealt with them. In particular the evidence indicates the best outcomes are achieved through collaborative models of health care where nurse prescribing is supported by a medically led and delegated team environment. Without such a model, we risk introducing fragmentation of care, and a range of potential detrimental outcomes, as elaborated further below.

The AMA has considered the Board's proposal against its policy position and the requirements of the Australian Health Ministers' Advisory Council *Guidance for National Boards: Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines* (the AHMAC Guidelines) which was endorsed by Australian Health Ministers in 2016 and form part of requirements under section 14 of the National Law governing registered health practitioners.

Evidence and rationale

The Nursing and Midwifery Board has not yet made a good case for the benefits of registered nurse prescribing or the need to change current prescribing restrictions. The AHMAC Guidelines require that non-medical practitioner national boards must address a range of matters in their applications, including a well-documented service need, a rigorous evidence-based approach, and compatibility with quality use of medicines.

Evidence to support registered nurse prescribing

The Board's latest proposal provides minimal references to support its statements about the safety, quality or cost effectiveness of registered nurse prescribing, or patient benefits or clinical outcomes.
Assumptions continue to be made that expanding scopes of practice is the answer to meeting unmet demand and providing cost effective, high quality care despite there being little to no high-quality evidence to support these assumptions.

A recent Cochrane review of non-medical prescribing for acute and chronic disease management in primary and secondary care[1] found mixed levels of evidence around a range of health management outcomes. Many of the studies reviewed involved nurses. There appeared to be moderate to high levels of evidence that with appropriate training and support, nurses were able to prescribe medicines as part of managing a range of conditions.

The majority of studies focused on chronic disease management with moderate certainty of evidence supporting positive outcomes for managing – specifically –high blood pressure, diabetes, and high cholesterol. Importantly, in these studies non-medical prescribers frequently had medical support available in a collaborative care practice model.

However, overall there was poor level evidence for prescribing outcomes in relation to avoiding adverse events and achieving health economic (cost effectiveness) outcomes. In addition, in the majority of studies reporting medication use, non-medical prescribers prescribed more drugs, intensified drug doses and used a greater variety of drugs compared to usual care medical prescribers.

This is of particular concern considering that Australia and other developed countries are currently seeking to reduce overprescribing, e.g. antibiotics and opioids. Promoting patient discussions about non-pharmacological solutions should be a priority rather than expanding the range of prescribers.

On the basis of the evidence available, the AMA continues to be sceptical about the benefits to patients on the grounds of risks to patient safety and poorer quality use of medicines.

Workforce shortages and other barriers to patient access

The Board's consultation paper continues to argue that prescribing by registered nurses will improve access to medicines for communities. No recent data or evidence is provided to support this statement.

Australian Bureau of Statistics (ABS) and Department of Health data indicate instead an improvements in patient access to medical practitioners over the last ten years.

The number of medical practitioners per 100,000 of the Australia population – both specialists and general practitioners – is substantially higher now than it was in 2001[2].

The number of general practitioners has increased substantially over the last ten years particularly in outer regional, remote and very remote areas. The data show increases whether it is for the total number of GPs, number per 100,000, full service equivalents (FSE), or FSE per 100,000. For example in very remote areas of Australia, in 2016-17 there were 355 GPs per 100,000 population compared to 192 in 2006-7; and there were 65.5 FSE GPs per 100,000 in 2016-17 population compared to 40.4 in 2006-7.[3]
The most recent ABS survey of patient experiences in Australia also shows an improvement in 'people waiting longer than they felt acceptable' to see a GP – falling from 23% in 2013-14 to 18% in 2016-17.[4]

The AMA is not suggesting that people living in rural and remote Australia do not experience difficulties in accessing health care compared to people living in urban areas. However, difficulties of access alone – largely related to distances rather than numbers of health professionals per se – does not justify compromising the quality of care provided to patients living in rural/remote areas.

As well as numbers of medical practitioners increasing, technological solutions have also rapidly evolved to improve access to more convenient, immediate and higher quality health care. As well as providing more patients with direct consultations with medical practitioners, this technology now allows non-medical health professionals caring for patients to access appropriate supervision by, and collaboration with, a medical practitioner by video-conference, health care applications, email or simply by telephone. There would be very few situations or circumstances where this could not occur.

Expanded scopes of practice for non-medical health practitioners should not be offered as solutions to medical workforce shortages. Regional, rural and remote Australians should have access to the same standards of clinical care that the wider population enjoys.

Funding and cost-effectiveness

Good evidence needs to be provided to support the cost-effectiveness of registered nurses prescribing. As noted above, studies indicate nurses may prescribe more drugs and a greater variety of drugs than medical practitioners.

In addition to direct and indirect costs associated with greater prescribing, other costs associated with the Board's proposal include:

- the supervision of registered nurses by a 'partner authorised prescriber'
- the additional professional indemnity insurance required to cover prescribing nurses, their 'partner authorised prescribers' and their employers
- the development and ongoing monitoring of employers' prescribing governance frameworks to cover registered nurse prescribing as proposed in the Board's consultation paper.

The above costs will be considerable and should not be underestimated. The current prescribing by nurses under protocol in the public hospital system is supported by an entire health bureaucracy with built-in training; safety, reporting, audit, and control mechanisms; and government-backed funding/insurance.

It should also be noted that MBS and PBS subsidies are only available for services and prescriptions made by nurse practitioners and midwives who are in a collaborative arrangement with a medical practitioner.

Medical services and prescriptions for medicines that cost more than the MBS/PBS copayment amount, provided by registered nurses working outside the public system could therefore cost patients more than those provided by medical practitioners. There is no certainty that the Federal Government would support extending access to MBS and PBS subsidies to registered nurses, particularly given the potential increase in expenditure resulting from increasing the range of prescribers.

AMA position

The AMA detailed its position on nurse prescribing in its previous submission and includes it again to illustrate its concerns with the Board's current proposal.

The AMA values the expertise and contribution of nurses in providing health care services and caring for patients.

The AMA supports models of care which fully utilise nurses' training and expertise, within their scopes of practice.

The AMA also supports the development and establishment of nationally consistent approaches to prescribing by non-medical health practitioners, and therefore supports the approach agreed by the Council of Australian Governments (COAG) and administered by the Australian Health Practitioners Regulation Agency in order to ensure this occurs.

All non-medical boards must comply with this process.

Within this context, the AMA supports models of health care where nurses may prescribe within their scopes of practice in a medically led and delegated team environment.

The AMA does not support independent or autonomous prescribing of Schedule 4 and 8 medicines by non-medical health practitioners (with the exception of dentists).

Models of non-medical health practitioner prescribing

As stated above, the AMA supports collaborative models of health care where nurses work as part of a medically led team.

The AMA supports non-medical prescribing underpinned by the following principles:

- Non-medical prescribing occurs in a medically led and delegated team environment.
- Non-medical prescribing occurs in the context of 'role delegation' not 'task substitution'.
- There must be formally documented, collaborative arrangements that ensure:
    - diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner
    - clear lines of accountability and responsibility
    - separation of prescribing and dispensing (with limited exceptions as appropriate in rural/remote circumstances)
- Non-medical practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education and training courses.
- Course curriculum must meet core competencies in determining when not to prescribe and/or when to refer patients to a medical practitioner.
- As occurs for medical practitioners, non-medical practitioners should be closely supervised during their first year of prescribing practice.

Models of non-medical prescribing supported by the AMA include:

- prescribing by a protocol or limited formulary;
- initiating therapy according to protocol or symptoms; and/or
- continuing, discontinuing and maintaining therapy according to a pre-approved protocol.

Nurse prescribing models

Care provided by nurses, including prescribing, often occurs under a protocol that covers the care provided by a clinical unit. These protocols typically set out:

- the medications a nurse practitioner can prescribe
- in what circumstances they can prescribe
- when the nurse practitioner will refer the patient to a medical practitioner.

As indicated by current evidence, the AMA supports models of care which involve nurses in the management of chronic conditions in the primary care sector, for example, where a general practitioner oversees the patient's care and determines the care plan, and a nurse follows the treatment protocols and notifies the GP before making changes to a patient's medications.

Proposed model for a new registration standard applying to registered nurses for endorsement to prescribe in partnership

As detailed above, the Board must strengthen its case in support of registered nurse prescribing – in terms of unmet need; safety and quality use of medicines; and cost effectiveness – in order to meet critical requirements of the AHMAC Guidelines.

This is a prerequisite to considering the detail of the proposed endorsement model outlined in the Board's consultation paper.

However, the AMA has the following points to make about the proposed model itself.
Prescribing in 'partnership'

The AMA does not agree this term describes the model proposed by the Board or the examples of nurse prescribing provided on pages 12 and 13 of the consultation paper. The term 'partnership' is inaccurate and misleading; misrepresents the level of autonomy a nurse would have; and provides an unrealistic expectation by both nurses and patients about a nurse's level of responsibility, expertise and independence.

The Health Professionals Prescribing Pathway describes this model as 'prescribing under supervision'. The AMA considers this is the appropriate description for what is being proposed and would reduce misunderstanding. Alternatively, the model could be termed as 'prescribing under delegation' or 'within a delegated model'.

Definition of 'partner' authorised prescriber

The AMA cannot support the proposal that a registered nurse could be supervised by a nurse practitioner. This is not consistent with current MBS and PBS restrictions which require a nurse practitioner to be in a collaborative arrangement with a medical practitioner.

This requirement recognises that only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Only medical practitioners currently meet all of the high standards required by the NPS MedicineWise Prescribing Competency Framework in order to safely prescribe independently.

The authorised prescriber must be a registered medical practitioner.

Post registration experience

The AMA considers that two year's full-time equivalent initial registration experience is insufficient.

Closely supervised practice

The AMA's position is that this period should be a minimum of 12 months for any non-medical practitioners.

Employer clinical governance framework

The framework must include an individualised written policy updated annually and signed by the registered nurse and delegating/supervising medical practitioner that determines details such as the specific medicines, patients, prescribing circumstances, safety checks and referral triggers that must be followed.

Conclusion

The AMA's final comment is that all the requirements of the Australian Health Ministers' Advisory Council Guidance for National Boards: *Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines (the AHMAC Guidelines)* must be met before any changes are contemplated. These were endorsed by Australian Health Ministers in 2016 and provide an important 'check and balance' to ensure that an application for prescribing is truly a response to community need, based on evidence, and not an unnecessary or counterproductive expansion of scope of practice beyond what is considered reasonable.

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[2] Australian Bureau of Statistics *Doctors and Nurses* 2013
http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20April+2013#p5
[3] Department of Health *GP Workforce Statistics* 2001/2 - 2016/17
http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1
[4] Australian Bureau of Statistics *Patient experience in Australia: summary of findings* 2016-17
http://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0