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AMA submission – Registered nurse and midwife prescribing models

The AMA is pleased to respond to the discussion paper – *Registered nurse and midwife prescribing* – released by the Nursing and Midwifery Board of Australia regarding nurse and midwife prescribing of scheduled medicines.

Several goals and issues are raised and discussed in the discussion paper. However it is not exactly clear what the objective of the Board is in this consultation.

In the absence of clarity, the AMA has provided this submission on the basis that the Board is seeking comments on

- a proposal to expand the scope of practice of nurses and midwives to the effect that they are endorsed by the Board to prescribe Schedule 4 and 8 medicines

and that views are also being sought on

- the models of nurse/midwife prescribing, under which endorsement would occur, to 'provide safe and effective access to health care'.

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

The AMA supports models of care which fully utilise nurses' and midwives' 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 collaborative models of health care where nurses and midwives 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).

The reasons for the AMA's views and its position are expanded below.

Evidence and rationale

Evidence to support independent nurse and midwife prescribing

It is concerning that the discussion paper does not reference statements made about the safety, quality or cost effectiveness of independent nurse/midwife prescribing. Neither are references provided to support statements about patient benefits or clinical outcomes.

Instead, 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 therefore continues to oppose independent or autonomous prescribing by nurses and midwives on the grounds of risks to patient safety and poorer quality use of medicines.

Instead, 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.

Workforce shortages and other barriers to patient access

The discussion paper argues that prescribing by registered nurses and midwives 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.

Current prescribing scope in Australia

Commonwealth legislation effectively restricts privately practicing midwives and nurse practitioners from practicing – or prescribing – independently, recognising the limitations of nurse/midwife scopes of practice and in support of the quality use of medicines. Midwives and nurse practitioners must be in a collaborative arrangement with a medical practitioner in order to access MBS rebates for services and PBS subsidised medicines[5].

Midwives and nurse practitioners therefore cannot, as is suggested in the discussion paper, already prescribe independently.
Midwives and nurses who are salaried or working in the public system are not accessing Medicare subsidies and are practicing and prescribing within collaborative arrangements with medical practitioners and in line with proscribed protocols.

Models of non-medical health practitioner prescribing

As stated above, the AMA supports collaborative models of health care where nurses and midwives 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 years 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 and midwife 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 fully 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.

In the case of midwives, the AMA also continues to support collaborative models of care, but cannot support independent midwifery practice.

The Australian College of Midwives *Scope of practice for midwives in Australia* document states that:

> 'A midwife in Australia is authorised to provide maternity care on their own responsibility to women with non-complicated pregnancy, labour and birth and during the postnatal period up to six weeks after their baby is born.'[6]

The scope of practice of a midwife is clearly focused on non-complicated pregnancies; prescribing S4 or S8 medicines during pregnancy or labour arises from a condition deviating from the norm. Best practice therefore indicates that if a midwife believes a woman's condition requires a prescription, then consultation with a medical practitioner is required. The correct investigation and diagnosis of a condition should be a prerequisite of any medicine prescription. Prescription is only a single part – usually the final part – of a continuum of care (as described in detail in the NPS MedicineWise *Prescribing Competencies Framework* referred to below). This involves aspects of examination, investigation and understanding of therapeutics which are currently beyond a midwife's scope of practice because they require completion of a medical course. Similarly, once a medicine has been administered to a woman in labour, there needs to be access to backup services from an obstetrician to supervise and manage care of the mother and a paediatrician to supervise care and management of the baby.

There are also potential perverse outcomes from independent midwife prescribing. For example, independent prescribing of intramuscular opioids by midwives, without consideration of alternatives, would constitute inferior care with higher rates of maternal and perinatal morbidity compared to an epidural analgesia provided by a specialist or GP anaesthetist.

Prescribing standards and training

Safe, high quality patient care depends on multidisciplinary teams of health care practitioners working together within their scopes of practice.

Medical practitioners are currently the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand and recommend the full range of clinically appropriate treatments for a given condition.

The NPS MedicineWise *Prescribing Competencies Framework* provides the benchmark for safe, appropriate and quality prescribing. The Framework sets high standards of competencies for independent diagnosis and prescribing and requires that the prescriber is responsible and accountable for their prescribing decision. Only medical practitioners currently meet the high standards set by the Framework in order to safely prescribe independently.

Independent prescribing of Schedule 4 and Schedule 8 medicines should only be practised by health practitioners whose core training fully and comprehensively achieves the competencies set out in the Framework.

Currently, only medicine and dentistry core education and training programs deliver the full set of required competencies and therefore meet the 'autonomous prescribing category' described in the Health Professionals Prescribing Pathway.

Framework for expanding scopes of practice and prescribing

Under the Health Practitioner Regulation National Law Act, which governs the practice of registered health practitioners, the national boards are responsible for setting the accreditation standards for education and training for the knowledge, skills and professional attributes to practise the profession.

In the interests of supporting patient safety and cost-effectiveness for the health care system, the AMA's view is that any expanded scopes of practice by non-medical health practitioners must be underpinned by a process that ensures:

- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

In addition, processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies; and
- there are documented protocols for collaboration with other health practitioners.

The AMA therefore supports the process agreed by COAG in 2016 that non-medical health practitioner national boards must follow in order to alter or expand endorsement to prescribe scheduled medicines or to alter or expand the list of scheduled medicines non-medical practitioners may be endorsed to prescribe.

The process is set out in the Australian Health Ministers' Advisory Council *Guidance for National Boards: Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines* which was endorsed by Australian Health Ministers in 2016 and form part of requirements under section 14 of the National Law.

The 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.

At this stage, it does not appear that the Board's discussion paper addresses any of these matters.

Neither does the discussion paper makes any mention of the COAG requirements, whether this consultation forms part of this process, whether the discussion paper is preliminary to a formal application process, or something else.

This is concerning as all non-medical boards must comply with, and proceed within, this process in order to alter any scope to prescribe medicines.

The AMA requests the Nursing and Midwifery Board of Australia to provide clarification about its intentions to comply with the COAG requirements.

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[1] *Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care (Review)* Weeks G, George J, Maclure K, Stewart D, The Cochrane Collaboration 2016, www.conchranelibrary.com
[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
[5] Health Insurance Regulations 1975, clauses 2C-H
[6] Midwifery College of Australia *Scope of practice of midwives in Australia* 2016 https://www.midwives.org.au/resources/scope-practice-midwives-australia