RACGP
Royal Australian College of General Practitioners

Healthy Profession.
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3 August 2023

Nursing and Midwifery Board of Australia
G.P.O. Box 9958
Melbourne VIC 3001
Australia
via email: nmbafeedback@ahpra.gov.au

To the Nursing and Midwifery Board of Australia,

RE: Consultation regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber

Thank you for your email dated 16 June 2023, inviting feedback from the Royal Australian College of General Practitioners (RACGP) on the Nursing and Midwifery Board of Australia's (NMBA) Consultation regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber. This letter and detailed attachment form our response to the NMBAs consultation paper.

The consultation regulation impact statement (C-RIS) for the proposed Registration standard: Endorsement for scheduled medicines− designated registered nurse prescriber presents four possible non-regulatory and regulatory options for the proposed model and 26 specific consultation questions aimed to obtain feedback on the costs, benefits and impacts of the options provided within the C-RIS and how the proposed registration standard will work in practice.

The options presented were:

- Option 1 – Retain the status quo prescribing practice.
- Option 2 – RNs expand their scope of practice to prescribe Schedule 2,3,4 and 8 medicines under supervision, in accordance with governance frameworks and prescribing agreements.
- Option 2(a) – enable RNs to expand their scope of practice to prescribe only Schedule 2, 3, and 4 medicines under designation/supervision.
- Option 2(b) – enable RNs to expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines only under designation/supervision, except for RNs working in private practice or as a sole practitioner.

For reasons outlined in our accompanying submission, at this time, the RACGP supports Option 1 – 'Retain the status quo prescribing practice.' However, RACGP could potentially consider Option 2a in areas of **identified need and subject to more detail on the specific models and the conditions being treated**. The RACGP d**oes not support** RN prescribing of schedule 8 medicines.

The College would welcome the opportunity for further discussion with the Board. Should this be of interest to you, please contact Ms Samantha Smorgon, National Manager – Funding and Health System Reform on (03) 8699 0566 or via samantha.smorgon@racgp.org.au.

Best regards,

Dr Nicole Higgins
President

RACGP response to Nursing and Midwifery Board of Australia's Consultation regulation impact statement – Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber.

July 2023

RACGP

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RACGP response to Nursing and Midwifery Board of Australia's Consultation regulation impact statement – Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber.

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a response to Nursing and Midwifery Board of Australia (NMBA) *Consultation regulation impact statement: Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber*, framed from a general practice perspective.

The RACGP is Australia's largest professional general practice organisation, representing more than 45,000 members working in or towards a career in general practice including four out of five general practitioners (GPs) in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline. As a national peak body, our core commitment is to support general practitioners to address the primary healthcare needs of the Australian population.

The RACGP recognises the important role that nurses have in supporting patient healthcare.

Patients and primary healthcare providers have benefited significantly from the contribution nurses make to general practice. Nurses working in primary healthcare settings provide a breadth of opportunities to improve the health of the population through health promotion and illness prevention. Nurses working alongside GPs can increase efficiency and capacity within general practices. Like all health professionals, nurses should be appropriately supported to undertake their core function within an integrated primary healthcare system.

Executive summary

For reasons outlined in the following submission, at this time the RACGP supports Option 1 – 'Retain the status quo prescribing practice.' However, the RACGP would potentially consider Option 2a in areas of identified need and subject to more detail on the specific models and conditions being treated. The RACGP does not support designated RN prescribing of schedule 8 medicines.

A key role of general practice is to guide patients through the complexities of the healthcare system, and prevent unnecessary screening, testing and treatment. Every touch point in general practice provides opportunity to improve on multiple health outcomes. The increase in health system entry points, with multiple health professionals offering the same services, reduces opportunity for comprehensive care, adds to health system complexity, duplicates or fragments care, creates patient confusion around role delineation[1] and directs patients away from the essential coordinated medical care provided by their general practice. Fragmenting healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care. Losing this important opportunity for comprehensive and integrated care through task substitution could prove detrimental to patients. Local and international evidence shows that better support for, and use of, general practice is associated with lower emergency department presentations and hospital use[2,3,4,5,6,] decreased hospital re-admission rates[7], and significant savings for the healthcare system[8,9,10].

RACGP supports multidisciplinary teams which include a GP however they continue to lack appropriate funding.

Patient safety is paramount and best protected where multidisciplinary teams which include a GP, are working together to provide coordinated, collaborative and continuous patient care.

RACGP Position

The RACGP:

- **Supports** Option 1 – 'Retain the status quo prescribing practice.'
  - The recent Nurse Practitioner (NP) Workforce 10-year plan consultation suggests that more work is needed to maximise the already trained NP prescriber workforce before introducing another group of nurse prescribers.
  - More work needs to be done to improve distribution of GPs and NPs to remote and rural Australia.
  - Australian Primary Health Care Nurse Association has stated that practice nurses are underutilised in general practice.
  - The benefits from the new 60-day prescribing measure are yet to be realised and evaluated.
- **Could potentially consider** Option 2a – but only in **identified areas of need and under GP supervised care**.
  - Remote and rural areas
  - In identified areas of health need
  - Additional funding would be needed for GPs, general practices and ACCHSs to provide supervision and governance.
  - Supplying medicine under the guidance of a protocol where GPs have been involved in the development, and include specifics about what is prescribed, when and to whom.
- **Does not support** RN prescribing of schedule 8 medicines.
- **Does not support** proposed models of care that provide limited services for subsets of conditions or subsets of populations. **Fragmenting** healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care.
- **Remains concerned about approaching prescribing as a task that can be independently delegated. There is a conflation of diagnosing and prescribing skills, and the role of diagnosis in prescribing is being diminished.**
- **Identifies** a lack of understanding by other health professionals and policy makers about the specialty of general practice and the breadth of knowledge, experience, function, scope and responsibilities of generalist health professionals and their importance to the success of the Australian health care system.
- **Recommends** correctly identifying contemporary barriers to accessing care and exploring / implementing solutions that are currently presented and underway at a federal and jurisdictional level.
- **Does not** believe that there has been enough evidence provided by the NMBA to assure patient safety if the initiative is progressed and identification of their associated responsibility. Well-funded pilots in acknowledged areas of need are required.
- **Recommends** that consultation and acknowledgment of Australian qualified prescribers occurs.
  - This consultation paper has been written by the nursing profession for the nursing profession.
  - The Registered Nurses Prescribing Working Group does not have full representation from authorised prescribers in Australia.
  - Prior submissions on the discussion paper and proposed Registration Standard have not been made available, nor prescriber concerns and solutions acknowledged in the current consultation.

RACGP response to the consultation questions

Statement of the problem

- ***Address inequities in access to timely, safe and appropriate quality healthcare, particularly in rural and remote areas, aged care and hospital settings and in settings with communities who do not always access mainstream services.***

1. Do you agree or disagree with the problems that have been identified?

While there is a need to enhance health workforce, task and role substitution (through introduction of multiple prescribers) independent of medical practitioner involvement is not the answer. Medical workforce shortages in general practice are better addressed by:

- improving support for medical training in general practice,
- improving MBS and WIP funding for existing prescribers,
- cutting the red tape required for UK trained doctors to work in Australia,
- incentives to encourage medical practitioners to work in rural/remote areas and underserved populations,
- ensuring workforces are being best utilised within their existing scope of practice.

The framing of the problem implies that the consultation is for a solution aimed at rural and remote areas, aged care, hospital settings and in settings with communities who do not always access mainstream services.

- There are established guidelines already used in rural and remote areas (eg CARPA Standard Treatment Manual for remote and rural practice) that can guide nurses, Aboriginal and Torres Strait Islander health practitioners and doctors in medication use. Under these guidelines, nurses can already supply medicines by protocol for acute conditions and continue therapy for chronic conditions.
- Nurse practitioners (NPs) can already prescribe in their scope of practice.
- This proposed new framework expands upon the number of nurses who will be able to prescribe.
- There is insufficient detail about the types of prescribing that can be conducted in each healthcare setting and a framework for the types of prescribing that could be undertaken in specialised areas eg RACF, sexual health clinic etc. As such, this document appears to allow blanket prescribing by registered nurses (RNs) that could be taken up in urban areas as well as rural and remote areas.

Healthcare in rural and remote locations is nuanced and favours flexible arrangements over rigid policy. Whilst nurses and NPs can play an important role in areas of need working in partnership with other healthcare providers, nurses and NPs working independently is not a long-term workforce solution as it creates a two-tiered system. All patients should have access to a GP who can coordinate their care, whilst also providing high quality, safe medical diagnosis and management for all presentations in the community context.

The RACGP is concerned that Australian policymakers continue to propose new workforce solutions based on overseas models of primary care that require expansion of independent scope of practice for other health professionals. These proposals are often profession-led and the volume and quality of evidence for patient health outcomes and cost-effective healthcare utilisation does not stack up compared to the large evidence base supporting the cost-effectiveness of GP-led care. **Local and international evidence shows that better support for, and use of, general practice is associated with lower emergency department presentations and hospital use[11,12,13,14,15], decreased hospital re-admission rates[16], health benefits for Aboriginal and Torres Strait Islander communities[17,18] and significant savings for the healthcare system[19,20,21].** Despite modelling in other countries, there is no evidence that expanded scope of practice has assisted with medical practitioner workforce concerns or improved distribution to areas of need.

There also does not appear to have been sufficient consideration given to the budgetary impact of independent practice by nurses accessing Pharmaceutical Benefits Schedule.

Whilst expanding scope may assist with improving job satisfaction and retention, it should not be the driving motivation for change. These alternative models propose siloed care and do not capture the broad range of health professionals in primary care such as GPs, rural generalists, Aboriginal Health Practitioners and Workers, nurse practitioners and allied health professionals.

The development of the framework appears to have included representation from a large working group of nurses, nursing academics and one pharmacist, but no medical representation. While some consultation has been conducted (eg with RACGP) the concerns raised by our organisation are not fully presented in the discussion document and this reduces confidence in whether other groups' concerns were also adequately represented in the discussion.

2. What effects do you think these problems could have on people accessing healthcare?

Limited availability of services by GPs, as some areas continue to lose GPs with workload increases and perceived lack of support. This results in delayed access to diagnosis, treatment and other supports worsening patient outcomes.

3. Do you have any information, analysis or data that is relevant to the issues being discussed?

- National Medical Workforce Strategy (NMWS) 2021-2031. 2021
- Innovations in Care for Chronic Health Conditions. Productivity Commission. 2021
- Health Workforce Queensland. Health Workforce Needs Assessment. February 2023
- Health Workforce 2040: Nursing and Midwifery (Tasmania)
- Health Workforce 2020: Medicine (Tasmania)
- Gratton Institute. Pointer for improving primary healthcare. July 2023.
- Jurisdictional government health workforce webpages.
- Nurse Practitioner Workforce Plan. 2023
- Evidence base for additional investment in rural health in Australia. June 2023

4. Are there any other problems that you think should be considered as a part of this Consultation regulation impact statement (C-RIS)? If so, please describe what these are and how these problems should be addressed.

Introducing another model of care

It is the RACGP's understanding that RNs already facilitate increased access to medicines in underserved areas. Therefore, the RACGP does not see a need to expand the prescribing role of RNs more broadly. Remote practice in the Northern Territory (NT) provides an example of primary care nurses supplying medicines, in an area of need, and according to protocols under the guidance from medical practitioners. Consider adopting existing models like CARPA in rural areas. However, there are additional risks to consumers due to the relative lack of training in this setting and medical supervision is still always required and available by phone. This model also has typically not been funded by MBS but utilises salaried employees within organisations.

Complexity and risks of prescribing

The complexity of prescribing and the risks of prescribing have not been adequately discussed in the consultation paper. There is a major conceptual error in all non-medical practitioner "prescribing" proposals as it frames "prescribing" as an independent construct and task that can be delegated away. Prescribing must be seen within the context of broader clinical care management of the person, where a decision has been made to use a pharmaceutical product, among other management strategies. Prescribing requires in-depth experience and training in diagnosis, treatment and drug interactions. The proposal also does not consider non-drug interventions and quality de-prescribing strategies. De-prescribing (reducing the number of medications) is an active process for GPs in the context of the patient's medical history and the broader Quality Use of Medicines perspective. If a patient presents to an RN for a prescription, there is reduced opportunity for meaningful medication review.

If a clinician doesn't take clinical and medicolegal responsibility for the management of the health condition for which the "prescribing" is ostensibly for, then they shouldn't be doing the prescribing. Policy makers are simultaneously trying to implement systems where even less experienced clinicians take on prescribing as if it were an administrative role.

A visit to your GP is not just about prescription. An analysis of over 1.5 million GP-patient encounters in Australia confirmed that the majority of GP appointments made specifically to request medication actually resulted in additional healthcare needs being addressed during the same visit.[22] Losing this important opportunity for comprehensive and integrated care could prove detrimental to patients.

Improved technology and the introduction of telehealth and e-prescribing has supported better patient access to more convenient and timely healthcare. This technology also enhances appropriate supervision and collaboration between medical practitioners and other health professionals and could be better utilised.

A nurse prescriber would only need to undertake three years of undergraduate training and complete a short course. Detail is not provided in this consultation paper regarding the length or content of the prescribing training provided. Additionally, history taking, patient examination and correlation with radiology/ pathology findings are a critical part of prescribing that is not considered in this discussion paper.

Barriers to access to care

If there are barriers to access CARE, then this is what needs addressing.

If there are barriers to access to prescription medications due to administrative process issues (e.g., "prescription runs out"), then those processes should be addressed rather than creating new prescribers. The 60-day prescribing measure has not yet been implemented, so the impact that this may have on access is yet to be seen. The proposed measure is anticipated to significantly benefit patients and the health care system by freeing up. GP appointments, increasing access for patients and reducing current burden on the primary and acute health care system.

Introducing telehealth item numbers to allow GP consult with RNs and health professionals in RACFs would facilitate access to medical opinions and medicines without the need for nurse prescribing.

Healthcare Workforce

All areas of health workforce are experiencing workforce shortages at this time. Team based care needs to be constructed in such a way that increases net productivity for the same workforce. Fragmentation of care across a number of providers will decrease efficiencies and outcomes and increase costs.

Encouraging multiple prescribers will contribute to the growth of a two-tiered healthcare system. As a result, patients who cannot access GP services (for example due to cost or geographic location) will instead see the nurse as their first point of contact. This has the potential to reduce equality of care and increase health disparities for already disadvantaged communities.

The RACGP acknowledges the need to address medical workforce maldistribution issues that particularly affect patients located in rural, remote or Aboriginal and Torres Strait Islander communities and is working with Government on this. Patients in these communities have the right to the same standard of medical care as patients in metropolitan and regional areas.

The RACGP continues to advocate for and support initiatives which strengthen rural general practice and increase the number of doctors working in rural and remote Australia and other areas of workforce shortage.

Gaps in medical workforce can be addressed by a suite of measures that include improved pay and conditions, increased training pipelines, better informed workforce planning and reduced barriers for doctors from countries such as UK.

Appropriately funding the general practice workforce will see an increase in medical students entering the profession. There remains genuine interest in general practice as a career, but system and funding issues are a deterrent.

Improved technology and the introduction of telehealth and e-prescribing has supported better patient access to more convenient and timely healthcare. This technology also enhances appropriate supervision and collaboration between medical practitioners and other health professionals.

Nursing workforce shortage and maldistribution

The C-RIS focussed on general practitioner workforce issues but failed to acknowledge and represent current and forecasted workforce issues for nursing, midwifery, and allied health professionals. Currently there is a strategic national project 'supply and demand study' underway which will quantify the nursing workforce in Australia and forecasting workforce requirements at the national and state and territory levels. As the key focus of the C-RIS and proposed registration standard is the registered nurse, the failure to include RN workforce data is an alarming omission.

It is not immediately apparent from the C-RIS that the nursing workforce is also limited and maldistributed. The APNA Annual Report 2022 states that "there are 96 000 nurses who work outside the hospital system. This includes nurses in general practice, aged care, Aboriginal and Torres Strait Islander health, correctional facilities and other community settings." Australian Institute of Health and Welfare's A profile of primary health care nurses – 2019 indicates that "at least 82,000 nurses work outside of the hospital setting including nurse practitioners, registered nurses, enrolled nurses and registered midwives…Two-thirds of primary health care nurses reported working in general practice in 2019 (68%)". Yet, many general practices struggle to attract and retain practice nurses to work at existing scope of practice. Similarly, there is an acute shortage of qualified nurses to work in the aged care sector.

The 2022 and 2023 Health Workforce Needs Assessment, Health Workforce Queensland, outlines challenges in retaining the primary health care nursing workforce that have not been mentioned within the C-RIS. Challenges identified include significantly lower wages than the public sector, management ability, emotional exhaustion, lack of available housing, lack of access to professional development, insufficient access to childcare, lack of access to casual and locum workforces and workplace safety.[23,24]

Nursing workforce shortages are likely to continue in primary health care if the identified challenges of pay and conditions are not addressed. [23,24] This needs to be addressed before embarking upon expanding scope of practice to include prescribing.

Further exacerbating nursing workforce concerns was the passing of legislation requiring residential aged care services to have 24/7 access to a registered nurse. There is further commitment to increase the average minimum care minutes (RN). These initiatives in one sector will likely continue to drain the already strained supply of nurses in primary health care. [24,25]

The role of nurse practitioners who have done an additional master's degree and significant hours of training in order to be able to prescribe will be undermined by this model.

Costs associated with fragmented care

A key role of general practice is to guide patients through the complexities of the healthcare system, and prevent unnecessary screening, testing and treatment. The increase in health system entry points, with multiple health professionals offering the same services, adds to health system complexity, duplicates or fragments care, creates patient confusion around role delineation[26] and directs patients away from the essential coordinated medical care provided by their GP practice.

The below figure shows the associations between continuity measures as years with the same regular general practitioner (RGP) and odds for use of out-of-hours (OOH) services, acute hospital admissions and mortality for a 2018 Norwegian study.[27] This demonstrates that the length of the patient-RGP relationship is significantly associated with lower use of OOH services, fewer acute hospital admissions and lower mortality. "The presence of a dose-response relationship between continuity and these outcomes indicates that the associations are causal".

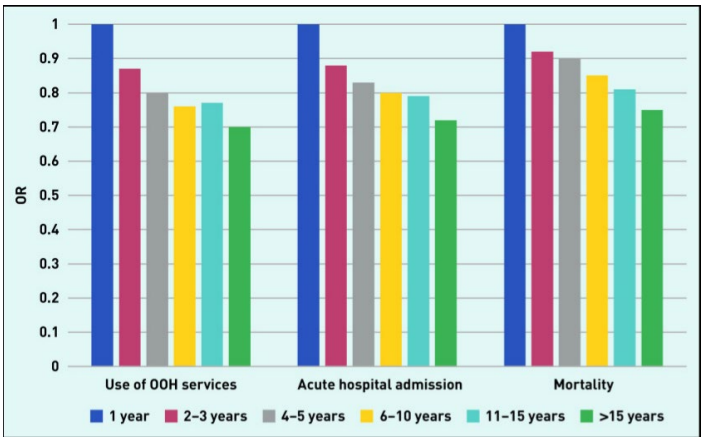

Figure 1:

Length of patient-same doctor relationship is associated with lower use of out-of-hours services, fewer acute hospital admissions and lower mortality.

Multiple prescribers create more risk for the patient and can contribute to overprescribing of antibiotics. A Cochrane review of non-medical prescribing for acute and chronic disease management in primary and secondary care found that non-medical prescribers prescribed more drugs, intensified drug doses and used a greater variety of drugs compared to usual care medical prescribers.[28]

Episodic and independent care from multiple providers risks undermining the quality and efficiency of the Australian healthcare system and results in poor patient outcomes.[29] This results from factors such as a lack of consistency and unified medical records, ineffective clinical handover, missed opportunities for patient follow up and learning from patient interactions, the provision of contradictory clinical advice, missed opportunities to detect contra-indications and to initiate a range of opportunistic health promotion activities and diminished clinical governance and accountability. Losing this important opportunity for holistic, comprehensive and integrated care could prove detrimental to patients.

Consumer / patient safety is paramount and best protected where health service providers are working together respectfully and appropriately, communicating fulsomely, with instruments such as GP Management Plans and Team Care arrangements. Using skills, expertise and established scopes of practice in complimentary and not competitive ways to best serve patients.

RACGP Question 1: Is the C-RIS an adequate (comprehensive) assessment of unintended consequences, including adverse health outcomes of designated RN prescribing?

Cost-effectiveness and funding

There is no clear evidence that nurse-doctor substitution saves money or reduces the workload of GPs. A US study[30] of NPs working in an emergency department showed that compared to physicians, NPs incur greater resource costs to treat patients yet achieve worse patient outcomes. The study also highlighted that NPs were more likely to prescribe drugs with potentially high errors of omission (i.e. antibiotics). In summary it suggests that NPs practising independently are not cost efficient. Given NPs have more training than RNs, it could be assumed that cost-effectiveness of nurse-led prescribing could be worse.

Fixed salary rather than fee-for-service would reduce issues currently experienced by GPs with the perverse incentivising of paying more for shorter consults and resulting in high turnover, potentially lower quality GP services as the MBS disincentivised longer consultations that are necessary in chronic disease and mental health care.

Designated RN prescribers accessing the PBS could very quickly lead to greater expenditure in addition to potential for worse clinical outcomes (anti-microbial resistance, over-use of PPIs, RN prescribes ARB while GP is already prescribing ACEi, use of expensive "new" drugs (eg asthma, DM).

The RACGP maintains that better support for the provision of general practice-based primary care can be achieved through implementing the *RACGP Vision for general practice and a sustainable healthcare system*.

This would include increased funding for general practices to employ, coordinate and lead a team of qualified health professionals, including nurses, through the Workforce Incentive Program (WIP). The RACGP supports the WIP Practice Stream as it recognises the additional time required for GPs to effectively lead patient care across the multidisciplinary care team and encourages more general practices to employ NPs as part of a general practice-based multidisciplinary care team.

Although nurse prescribers under GP supervision may allow for more task substitution, a qualified GP must still be available to work with or supervise their role. This ongoing supervision increases time burden and liability for GPs, particularly in rural and remote areas, and nullify any benefit of task substitution. Further, the complexity of the clinical governance framework required to support such task substitution suggests it would unlikely be cost-effective for employers.

General practices in Australia vary; their services depend on the types of populations they serve. Hence the services provided by a registered nurse may differ across the sector. **In delivering a high-performance health system, it is necessary to allocate resources carefully and effectively and assess the cost-effectiveness of services**.

Continuity of care in multidisciplinary teams

Team-based care is widely recognised as best practice in the delivery of primary healthcare services. Team-based care models, such as the patient-centred medical home (PCMH), are characterised by multidisciplinary healthcare teams working together to provide coordinated, collaborative and continuous patient care. There is evidence that team-based care contributes to reduced hospital readmission rates and emergency department presentations.[31]

There is also a substantial body of literature that demonstrates the benefits of care continuity with respect to patient satisfaction, reduced mortality, reduced emergency department presentations and reduced avoidable hospital admissions, particularly for the heaviest users of healthcare.[32, 33, 34]

The RACGP's support for a team-based approach to providing healthcare is reflected in the:

- Vision for general practice and a sustainable healthcare system
- Standards for general practices (5th Edition)
- Curriculum for Australian General Practice
- Position statement on the role of specialist GPs.

Patient needs and the health system are becoming increasingly complex. GPs, in their role as health system stewards, help ensure continuous, comprehensive, high-quality, whole-person patient-centred care.

The Australian Government has recognised general practice as the most appropriate setting in which to provide person-centred, continuous, and coordinated care to the community.[35] General practices must remain the clear first point of contact for patients within the healthcare system, particularly in a system which is being reformed to focus on one health system, patient registration, and increased primary health care focus.

Education and training

Role and task substitution from GPs to other health professionals with inappropriate qualifications is not a solution to an undersized general practice workforce and unmet need for GPs.

Expanding the scope of practice of healthcare professionals without the same level of training as GPs can lead to fragmented and inefficient care, mis- or delayed diagnoses[36], inappropriate or delayed treatment – including pharmacological treatment, inappropriate referrals and interventions and/or adverse events resulting in physical or psychological harm to patient. It may lead to a two-tiered system, where patients who cannot access GP services (for example, due to cost or geographic location) receive care from another professional without the same level of qualification as a GP. This has the potential to reduce equity of access to high-quality healthcare, increase health disparities, drive down efficiencies and increase costs.

Section 5 – Options being considered.

5. Are there any additional options that have not been identified?

GPs as consultants to nurses and Aboriginal Health Workers, with GP led primary care.

Yes, however increasing numbers of GPs, rural specialists and health workforce who provide services to rural / remote populations and low-income populations should be a priority above investing in a single task (ie prescribing). Also note that there are shortages of RNs and nurse practitioners, including in rural and remote areas, and in aged care settings. Prescribing is time consuming and removes time from other care delivery.

Option 1: Retain the status quo prescribing practice. This option would mean that there are no changes to the current prescribing arrangements in Australia. This option would not require any additional regulatory action or legislative change.

6. What are the costs and benefits associated with retaining the status quo as identified by the Board?

Funds can be invested in better support for existing evidence-based models of care.

7. Are there other costs and benefits associated with retaining the status quo that the Board has not identified?

Professions and Governments can focus on plans already developed and in process of being implemented to improve health access and workforce issues. Introducing designated RN prescribing will distract from this national and jurisdiction work through the need to establish training, supervision, and other systems for little return on investment.

8. Do you agree or disagree with the costs and benefits associated with retaining the status quo?

No comment.

Option 2: RNs expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines under supervision, in accordance with governance frameworks and prescribing agreements.

9. Are there any other benefits or costs associated with Option 2?

There are additional costs and financial impacts. In private practice and ACCHOs, MBS does not provide sufficient funding for primary care nurse salaries. No MBS numbers are available for consultations where nurses prescribe for patients without seeing the doctor. This does not provide a financially viable model of care under the current system.

Cost of providing prescriber numbers for nurses and administration to support this, noting the number of nurses in Australia is much larger than for medical practitioners.

Additional risk of litigation is likely to increase medical indemnity costs for medical practitioners. There are substantial risks to patients and nurses when prescribing some Schedule 8 medicines and substantial education, training, experience and supervision would be required to mitigate the risks.

There is likely impact on increase costs for AHPRA -nursing in terms of registration/ complaints regarding prescribing.

It is important to acknowledge that prescribing, even in partnership, requires significant experience and training in diagnosis, treatment and drug interactions. Prescribers without the appropriate knowledge and skills would lead to more adverse events and increased use of GP time monitoring the prescriber.

10. Are there any unintended consequences with Option 2?

Patient safety

All prescribers need extensive training and knowledge to manage the complexities of multimorbidity, polypharmacy, non-routine aspects of the individual patient. This knowledge comes from the years of comprehensive training that far exceeds and is different to RN training. For medical students, training for 5-6 years results in an intern who only prescribes under close supervision.

The Prescribing Skills Assessment, adapted to Australia, from the British Pharmacological Society is the skills/knowledge-based assessment required of increasing number of medical schools.

The RACGP is concerned that introducing additional prescribers will increase volume of prescribing without consideration of quality de-prescribing and appropriate non-drug interventions. De-prescribing (reducing the amount of medications) is an active process for GPs in the context of the patient's medical history and the broader QUM perspective. If patients present to an RN for a prescription, there is reduced opportunity for meaningful medication review.

Nursing workforce shortage and maldistribution

Although not as immediately apparent, nursing workforce is also limited and maldistributed. Many practices struggle to attract and retain practice nurses of sufficient calibre to work at full existing scope of practice. Similarly, there is an acute shortage of qualified nurses to work in the aged care sector.

Models that fragment healthcare

RACGP should oppose proposed models of care that provide limited services for subsets of conditions or subsets of populations. Fragmenting healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care.

Impact on general practice

General practice would see the downstream effects of inappropriate patient management from non-medical prescribing. This may increase complexity and workload for GPs, decrease patient access to GPs and potentially worsen patient outcomes.

C-RIS, Page 10, option 2 states that the prescribing agreement must contain details of 3-month clinical mentorship however Appendix A states this period on clinical mentorship is 6 months this is an important requirement and must be clarified.

11. What impacts will Option 2 have for relevant markets, including impacts on prices and competitions?

No comment.

12. Are there any costs that have not been identified?

Ongoing funding to support supervisors and clinical governance.

If RNs were to prescribe, it would need to be part of a team-based approach, with adequate remuneration for GPs to provide supervision and clinical governance.

The RACGP is concerned about the impact that this would have on existing GP training programs where GPs are supervising the future medical workforce.

There is no clear evidence that nurse-doctor substitution saves money or reduces the workload of GPs.
Although nurse prescribers under GP supervision may allow for more task substitution, a qualified GP must still be available to work with or supervise their role. This ongoing supervision increases time burden and liability for GPs, particularly in rural and remote areas, and nullify any benefit of task substitution. Further, the complexity of the clinical governance framework required to support such task substitution suggests it would unlikely be cost-effective for

employers. Efficiency gains are not observable due to a high level of task duplication and patient confusion around role delineation.

13. Are there any hidden costs, related to PII etc?

The designated RN prescriber and authorised health practitioner must comply with the requirements of the *Professional indemnity insurance registration standar*d that is applicable to their profession. As such they are responsible for ensuring that their insurance arrangements cover all aspects of their practice.

RACGP Question 2: Is the government willing to subsidise the indemnity insurance (as currently done for Medical Defence Organisations) that would be required for RNs to prescribe?

14. Have the costs been accurately identified for RNs and current prescribers?

Nurse prescribing would not be likely to be safe/ cost effective unless part of the team and in discussion with the GP. Much like GP registrars are trained to enable them to be safe, nurses would need to be trained in the GP practice and supervised, unless they only had a very limited schedule of drugs to prescribe or were supplying medicines under protocol.

15. What impacts would Option 2 have on current prescribers?

Responsibilities under a prescribing agreement: The responsibilities of an authorised health practitioner (such as a medical practitioner or a nurse practitioner) under a prescribing agreement may not be realistic and manageable for a GP if extended to RNs. GPs undergo extensive medical training and possess comprehensive knowledge of various conditions and medications. Transferring prescribing responsibilities to RNs without adequate training and expertise may lead to potential risks and errors in patient care.

This will place an onerous uncosted burden on GPs who will be expected to mentor and then supervise RN prescribers. Practices will be expected to develop multiple uncosted systems to enact clinical governance frameworks and processes to ensure they are followed. The GP is providing supervision and bearing legal risk with no income associated with this process.

The logistic requirements of GPs supervising nurse prescribers has not been adequately considered in this document. No GPs or medical practitioners were involved in the development of this document.

As a GP there are many risks to supervising nurse prescribers in both private and government/ NGO clinics. Some GPs may choose not to work with nurse prescribers. There are legal risks to medical practitioners who supervise nurse prescribers, and they are at risk of bearing the costs of litigation as consumers are likely to sue the doctor and not the nurse (many cases where GP supervisors are sued over GP registrars would suggest this is the case).

In state and territory run health services or NGOs with other funding, salaries might be provided for nurses, and salaries provided for GPs, noting that this also means additional indemnity cover is provided by the state and territory health service as well as GP medical defence cover. This is the current system in place in remote areas in NT at present which makes it more viable.

GP VMOs and GPs in residential aged care are already able to chart medications according to protocols for nurses to use (eg palliative care, obstetric care, prn medication in RACF).

16. Do you believe that Option 2 would improve access to healthcare for consumers?

There are existing models that already allow for supply of medicines by nurses to improve patient access and therefore Option 2 is unnecessary. In remote primary care, a lot of treatments are initiated by remote area nurses and AHWs who followed protocol driven care for a wide range of conditions (the CARPA Standard Treatment manual). The GPs are consultants to nurse (and AHW) led primary care and the nurses and AHW initiate medicines, consulting with GPs where needed.

17. Do you agree or disagree with the impacts that have been described?

No comment.

18. Are there any risks associated with Option 2 that have not been identified?

General practice will be maximally affected but seems to have been minimally engaged with. The RACGP's 2018 submission recommendations do not appear to have been incorporated into this proposal.

Option 2a is preferred over 2b.

Option 2b is the least preferred option mainly due to risks of nurse working independently.

19. What is the perceived cost-benefit analysis for option 2?

No comment.

Option 2 (a): enable RNs to expand their scope of practice to prescribe Schedule 2, 3, and 4 medicines only under designation/supervision and Option 2 (b): enable RNs to expand their scope of practice to prescribe Schedule 2, 3, 4 and 8 medicines only under designation/supervision except for RNs working in private practice or as a sole practitioner.

20. Are there any other benefits or costs associated with Options 2(a) or 2(b)?

No comment.

21. Are there any unintended consequences with Options 2(a) or 2(b)?

Fragmentation of care. Multiple health professionals offering the same services (but with significantly reduced education. training and responsibility when compared to GPs), adds to health system complexity, duplicates, or fragments care, and directs patients away from the essential coordinated medical care provided by their GP practice. **Fragmenting healthcare has been shown to be less safe and more expensive than models that facilitate continuity of care.** Losing this important opportunity for comprehensive and integrated care could prove detrimental to patients and the healthcare system.

Pursuing alternative scope of practice models distracts from current issues and solutions and initiatives underway, contributing to health care failure.

Impact on GP training if supervisory roles need to be duplicated across two disciplines.

22. What impacts will Options 2(a) or 2(b) have for relevant markets, including impacts on prices and competitions?

No additional comment.

23. What impacts would Options 2(a) or 2(b) have on current prescribers?

No additional comment.

24. Do you believe that Options 2(a) or 2(b) would improve access to healthcare for consumers?

No additional comment.

25. Which option do you think would improve equity of access to healthcare for all consumers? Option 1, Option 2, Option 2(a) or Option 2 (b)

Refer previous comments.

26. Are there other options not presented that could address the problems identified?

Alternative options should be explored to address the identified problems, such as improving collaboration and communication between healthcare professionals.

Designated RN prescribers in GP-led teams working to a limited number of acute and chronic conditions like CARPA.RNs have historically worked well with GPs in a team-based environment, and this could work well in General Practice. However, the RN must be co-located with the GP in the practice, not work in a separate work environment e.g. independent of the GP in their own practice. This will ensure continuity of care and safety for the patient.

Presently, this is not a viable model in general practice due to insufficient funding for nurses within general practice and lack of funding for GPs in overseeing nurses.

The benefits that may occur from the introduction of 60-day prescribing are yet to be realised, therefore adding another prescriber is premature.

Other team-based healthcare settings such as palliative care, oncology, opioid treatment programs and sexual health clinics may be better suited to expanded scope for nurse prescribing (protocol based) due to a wraparound care model and access to medical professionals.

RACGP comments regarding consultation to date and how prior feedback has been incorporated in current consultation paper.

Lack of transparency on past consultations

- Development of the proposed standard and its original consultation occurred **4-5 years ago**.
- Past consultation submission papers are not available on NMBAs past consultation webpage nor was consultation reports made available yet the following detail was provided in the C-RIS. This was unable to be reviewed by stakeholders.

- The RACGP provided a submission on the 21 September 2018 to the 'Proposed registration standard: Endorsement for scheduled medicines for registered nurses prescribing in partnership'. In this submission the RACGP did not support the NMBAs proposal and stated many concerns that have not been incorporated into the C-RIS.

- The C-RIS - Appendix C: Previous consultation by the NMBA, did include RACGP feedback but presented as a single concern, please see below.

C-RIS Appendix C page 47.	2018 RACGP submission - summarised
• The key issue of concern for the RACGP was the ability for the endorsed RN to work in partnership with a nurse practitioner as this would mean that a patient would potentially not have any interaction with a medical practitioner.	• Introducing multiple prescribers is not the solution to addressing challenges in Australia's health system • The rationale for introducing the proposal can be managed through existing mechanisms • Healthcare reforms must support coordinated and continuous care • The NMBA's proposal to require two years' post-registration experience, and complete two units of additional study, is insufficient to facilitate quality prescribing. • The RACGP is concerned that introducing additional prescribers will increase volume of prescribing without consideration of quality de-prescribing and appropriate non-drug interventions and reduced opportunity for meaningful medication review.

- The Registered Nurses Prescribing Working Group was established to develop a framework and other resources to support the development of prescribing of scheduled medicines by RNs. Past and current members are persons holding the position of, or representing, Commonwealth and Jurisdictional Chief Nursing and Midwifery Officers, Nursing and Midwifery Board of Australia, Queensland University of Technology, University of Melbourne. The only profession represented outside nursing and midwifery was a past member, the Chief Pharmacist, South Australia.

RACGP Q3-5

Is the proposed registration standard contemporary?

Why haven't submissions been made transparent to stakeholders?

Where is the fulsome representation of the qualified prescribing workforce in Australia in the development of this critical change?

RACGP overarching comments regarding current C-RIS

Consultation timeframe

The RACGP has over 42,000 members and a consultation timeframe of six weeks (for a sector that has a large number of submissions) was not sufficient time to engage the membership in a complete way for such a large change. The C-RIS will have significant impacts for general practice, primary health care, and current initiatives underway. A longer consultation period would have ensured the C-RIS was well informed from stakeholders of the costs, benefits and impacts of the options provided.

Presentation of information

RACGP has general concerns about the presentation of information in the consultation paper.

The consultation paper included misleading statements such as:

- *"The recently released Strengthening Medicare Taskforce Report noted that Australia lags behind other countries in making the most of the skills of the primary care workforce (p.13)"*
    - This quote is taken out of context. The report is emphasising the need for funding systems in Australia to support multidisciplinary team-based models of care working together to support comprehensive continuity of care.[37]
- Designated RN prescribing or new scope of practice goes beyond what the report was recommending and will increase fragmentation, and result in disjointed, episodic care.

Further statements from the SMT report were used in the C-RIS:

- *Develop new funding models that are locally relevant for sustainable rural and remote practice in collaboration with people, providers, and communities. Ensure new funding models do not disadvantage people who live in communities with little or no access to regular GP care, and whose care is led by other healthcare providers.*
- *Work with states and territories to review barriers and incentives for all health professionals* ***to work to their full scope of practice*** *The taskforce also noted that there is a need to break down barries to interprofessional collaboration and teamwork, build trust between professions and accelerate cultural change to allow healthcare providers to work to* ***their full strength*** *in a coordinated approach that maintains the patient at the centre (p.13 SMT).*
- The Report is investing in coordinated, collaborative teams to deliver comprehensive care, not further fragmentation of care.
- This statement did not mention *'broadening…. expanding…. scope of practice of RNs'* (p.4 C-RIS)

It would be beneficial to first define **full** scope of practice for the nursing profession in Australia, compare this against current state (inc. Nurse Practitioners), and what barriers there are currently to working to full scope of practice, how full scope meets health care needs, and how that can be incentivised / optimised prior to endorsement of designated prescribing or development of new models.

Currently the NMBA have Registered nurse standards for practice (professional standard) and Scope of practice and capabilities of nurses and midwives factsheet. These documents provide guidance to RNs and all stakeholders regarding the responsibilities and capabilities of the profession and would be the foundational documents that outline full scope of practice. Prescribing is not within the varying scope of these documents for RNs. This is new scope.

Lack of representation and recognised input by prescribers

The proposed registration standard will impact general practitioners and primary care significantly however GPs have not been represented on working groups, RACGP feedback has not been incorporated in the development of the current consultation and examples used do not reflect general practice.

- *How would the model work - Examples of where a designated prescribing model may occur (p. 21 C-RIS)*
    - Of the examples provided none appropriately represented general practice and the impact, cost or benefit for designated RN prescribing in this context.

References

[1] Parker, R., Forrest, L., Desborough, J., McRae, I., Boyland, T. Independent evaluation of the nurse-led ACT Health Walk-in Centre. Canberra: Australian Primary Health Care Research Institute, 2011.
[2] Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161-e
[3] Barker I, Steventon A, Deeny SR. 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 (Clinical Research Ed) 2017;356:j84-j.

[4] Barker I, Steventon A, Deeny SR. 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 (Clinical Research Ed) 2017;356:j84-j.
[5] Nagree Y, Camarda VJ, Fatovich DM, et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. Med J Aust 2013;198(11):612–15
[6] Steering Committee for the Review of Government Service Provision. Report on government services. Canberra: Productivity Commission, 2018.
[7] Shen E, Koyama SY, Huynh DN, et al. Association of a dedicated post-hospital discharge follow-up visit and 30- day readmission risk in a Medicare advantage population. JAMA Intern Med 2017;177(1):132–35
[8] Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London: The King's Fund, 2018.
[9] World Health Organization. The world health report 2008: Primary health care now more than ever. Geneva: WHO, 2008
[10] Engstrom S, Foldevi M, Borgquist L. Is general practice effective? A systematic literature review. Scand J Prim Health Care. 2001 Jun;19(2):131-44.
[11] Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161-e
[12] Barker I, Steventon A, Deeny SR. 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 (Clinical Research Ed) 2017;356:j84-j.
[13] Barker I, Steventon A, Deeny SR. 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 (Clinical Research Ed) 2017;356:j84-j.
[14] Nagree Y, Camarda VJ, Fatovich DM, et al. Quantifying the proportion of general practice and low-acuity patients in the emergency department. Med J Aust 2013;198(11):612–15
[15] Steering Committee for the Review of Government Service Provision. Report on government services. Canberra: Productivity Commission, 2018.
[16] Shen E, Koyama SY, Huynh DN, et al. Association of a dedicated post-hospital discharge follow-up visit and 30- day readmission risk in a Medicare advantage population. JAMA Intern Med 2017;177(1):132–35
[17] Zhao Y, Thomas SL, Guthridge SL, Wakerman J. Better health outcomes at lower costs: The benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory. BMC Health Serv Res 2014;14:463
[18] Dalton APA, Lal A, Mohebbi M, Carter PR. Economic evaluation of the Indigenous Australians' Health Programme Phase I. Burwood, Vic: Deakin University, 2018
[19] Baird B, Reeve H, Ross S, et al. Innovative models of general practice. London: The King's Fund, 2018.
[20] World Health Organization. The world health report 2008: Primary health care now more than ever. Geneva: WHO, 2008
[21] Engstrom S, Foldevi M, Borgquist L. Is general practice effective? A systematic literature review. Scand J Prim Health Care. 2001 Jun;19(2):131-44.
[22] Trevena, L., Harrison, C., Britt, H. C., Administrative encounters in general practice: low value or hidden value care? Med J Aust 2018; 208 (3): 114-118. || doi: 10.5694/mja17.00225 Published online: 19 February 2018
[23] Australian Government. Department of Health and Aged Care. 2022 Health Workforce Needs Assessment. Health Workforce Queensland.
[24] Australian Government. Department of Health and Aged Care. 2023 Health Workforce Needs Assessment. Health Workforce Queensland.
[25] Australian Government. Department of Health and Aged Care. 24/7 registered nurse responsibility. Available from https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/24-7-rns
[26] Parker, R., Forrest, L., Desborough, J., McRae, I., Boyland, T. Independent evaluation of the nurse-led ACT Health Walk-in Centre. Canberra: Australian Primary Health Care Research Institute, 2011.
[27] Sandvik H, Hetlevik O, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. BrJ Gen Pract. 2022 Jan 27;72(715)

[28] Weeks G, George J, Maclure K, Stewart D, Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care (Review) The Cochrane Collaboration 2016.
[29] Frandsen B, et al, Care fragmentation, quality, and costs among chronically ill patients, Am J Manag Care. 2015: 21(5):355-362.
[30] Chan DC Jr, Chen Y. The productivity of professions: Evidence from the emergency department. National Bureau of Economic Research. October 2022.
[31] Riverin BD. Li P. Naimi AI. Strumpf E. Team-based versus traditional primary care models and short-term outcomes after hospital discharge. CMAJ. 2017;189(16):585-93.
32 Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6).
33 Western Australia Primary Health Alliance. Comprehensive primary care: What patient centred medical home models mean for Australian primary health care. Belmont, WA: WAPHA, 2016.
34 White ES, Pereira Gray D, Langley P, Evans PH. Fifty years of longitudinal continuity in general practice: a retrospective observational study. Family practice. 2016 Apr 1;33(2):148-533
[35] BEACH team. A decade of Australian general practice activity 2004-05 to 2013-14. General practice series no.37. Sydney.
[36] Murdoch J,Barnes R, Pooler J, et al. Question design in nurse-led and GP-led telephone triage for same-day appointment requests: a comparative investigation. BMJ Open 2014;4:e004515.doi:10.1136/bmjopen-2013-004515.
[37]Australian Government. Department of Health and Aged Care. (2022). Strengthening Medicare Taskforce Report.