AMA Queensland Submission

Commonwealth Scope of Practice Review Survey

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- **Benefits of expanded scope of practice: Who can benefit from health professionals working to their full scope of practice?**

  How can these groups benefit? Please provide references and links to any literature or other evidence.

  Firstly, it is important to differentiate 'full scope', at which all properly qualified practitioners are authorised to practice, from 'extended scope' which is often what is being referred to in reality, particularly by state and territory governments. AMA Queensland supports all health professionals working at the top of their scope in appropriate settings and subject to the satisfaction of education and training requirements.

  Australia already has important institutional processes established for the direct purpose of ensuring scopes of practice protect patient safety. These include those of Ahpra, the 16 National Boards, training colleges, state boards and the Therapeutic Goods Administration (TGA). The scopes of practice authorised by these bodies are robust and evidence-based, in line with best practice models of care.

  There are obvious and significant risks to patients and health system costs and efficiencies in extending scope beyond these appropriate controls. In addition, extensions of scope risk siloed working which puts clinicians at heightened risk of clinical error.

  All innovations in models of care must occur in a collaborative, multidisciplinary context to ensure checks and balances remain so patients are not harmed and practitioners do not face disciplinary action. There will only be detriment, not benefit, to changes in scope if they are implemented in the absence of these important safety controls.

  This is why AMA Queensland completely rejects the ad-hoc and dangerous approach taken by state governments, particularly Queensland's, in unilaterally amending Extended Practice Authorities to permit extensions of scope, often misleadingly characterised by Queensland Health as 'enabling' practice at the 'top' of scope. What's more, these decisions are the result of election commitments to vested-interest lobby groups and are not based in evidence or undertaken in the interests of patients.

Likewise, it is highly inappropriate that arrangements such as the various Community Pharmacy Agreements enable pharmacy owners who stand to gain financial benefit from extensions in scope to influence government decisions about scopes of practice. This must be addressed and removed from the pending 8thCPA.

AMA Queensland fully supports the submission of our Federal AMA body on all questions raised in this survey, including this question, and urges the reviewers to carefully consider its response in conjunction with the above.

- **Risks and challenges: What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice?**

The key risk from extensions of scope (as opposed to working at the 'top' of scope) is patient health. The causes of this risk are multiple but the most serious stem from siloed working and its absence of appropriate safety controls and increasing antimicrobial resistance.

For example, the authority to prescribe medications has been appropriately separated from the authority to dispense for many years as a deliberate and direct control on siloed, autonomous working. It is fundamental to patient safety because there are clear financial conflicts of interest where practitioners are allowed to both prescribe and sell medications.

Many health services are private businesses subject to the usual commercial pressures of other for-profit enterprises. The owners of these businesses have a clear financial incentive to encourage prescribing and over-servicing in the pursuit of profit, risking both the health of patients and professional integrity of their staff. This also clearly risks misdiagnosis or missed diagnoses of conditions, resulting in later presentations with more advanced illness and increased costs to the health system.

In addition, over- and inappropriate prescribing of antibiotics directly causes antimicrobial resistance, which has been designated by the World Health Organisation as one of the top 10 public health threats facing humanity.
It is imperative to patient health that extensions to scope do not undermine the integrity of the prescribing-dispensing separation and other important safety controls and do not occur in any setting other than collaborative and multidisciplinary teams. The risk to patient health and antimicrobial resistance is too great.

AMA Queensland reiterates the submissions of our Federal AMA body on this question.

Please give any evidence (literature references and links) you are aware of that supports your views.

A prime example of the risks inherent in siloed, autonomous working is the pharmacy-prescribing programs being implemented by the Queensland Government. These programs represent extensions to scope, not the enabling of practitioners to work at the top of their scope of practice which, as stated, AMA Queensland supports.

A survey of doctors by AMA Queensland about the government's UTI pharmacy-prescribing pilot revealed multiple clinical errors and resulting patient harms, including antibiotic allergies, ectopic pregnancies and cervical cancer. At least 9 patients ended up in hospital with sepsis or kidney and bladder infections due to ineffective or delayed reports and at least 240 doctors reported patient complications.

What's more, it is clear that the now-permanent implementation of this program has failed its stated purposes to address the chronic shortage of doctors throughout Queensland and reduce emergency department (ED) presentations and ambulance ramping. Queensland Health's own data showed ED TUI presentations actually increased by 50% since the program was made permanent, not decreased.

This was completely predictable since it is not presentations of so-called 'minor ailments' that cause ED pressures; it is bed block – a lack of in-patient beds – that prevents acute or chronic patients who must be in hospital from being admitted from ED onto wards. No number of extensions to scope can fix that problem.

Clearly, these errors must not be repeated and it is extremely alarming that the Queensland Government has decided to extend the North Queensland Pharmacy Scope of Practice Pilot state-wide before it has even begun, without evidence and on the back of these UTI pilot failures. This will only cost the public health system more, further fragment care and exacerbate hospital pressures.

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

  Please give examples and any evidence (literature references and links) you have to support your example.

  AMA Queensland submits the response of our Federal AMA body to this question.
  International models of care have been misrepresented in the justification by autonomous-prescribing advocates and falsely extrapolated to the Australian context. Many of these models are, in fact, examples of practitioners working to the top of their scope within collaborative, multidisciplinary settings, often led by medical practitioners. They do not involve extensions of scope with practitioners working in isolation. AMA Queensland rejects claims that these studies support the implementation of dangerous programs including those in Queensland.

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

  AMA Queensland reiterates the sentiment of our Federal AMA body that this question reveals an inherent bias in favour of removing appropriate controls on expansions of scopes of practice. This is a reckless approach given the risks set out in this submission and based on evidence emerging from failures of scope expansions such as that most recently in the field of cosmetic surgery. As stated, AMA Queensland supports all health professionals working at their 'full' or 'top of' their scope in appropriate settings and subject to the satisfaction of education and training requirements – extensions that lead to autonomous working threaten patient safety and must not be supported.

Changes to models of care require robust evidence of what works, not reliance on questionable 'pilots' or jurisdictions and programs that do not directly apply in Queensland. All models that extend scopes of practice must be within collaborative, multidisciplinary settings and only through genuine and comprehensive consultation with medical practitioners.

Australia's primary care system is amongst the best in the world, particularly our general practice sector. If governments were sincerely focused on increasing patient access whilst safeguarding safety, they would:

- enable and invest in multidisciplinary, collaborative teams within general practice (for example, authorising pharmacists working within general practices to vaccinate as their siloed community pharmacy colleagues are so authorised);
- incentivise GP registrars to move to the regions to increase access to primary care where its most needed;
- broaden workforce incentives to private practitioners to attract critical skills to regional, rural and remote areas; and
- repeal and remove all restrictions on pharmacy ownership and associated location rules which are anticompetitive and present barriers to entry and increases to competition in the pharmacy sector.

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

AMA Queensland reiterates the points above and the submission of our AMA Federal body. Again, we reiterate our support for health practitioners working to the top of their scope of practice and submit that such working is already enabled – where necessary education and training requirements have been completed and within appropriate settings, practitioners are currently able to work to their 'full' scope of practice without restrictions or barriers.

AMA Queensland has called for funding of a PhD research project examining medical practitioners' scope of practice, including detailed job analyses, to identify tasks currently undertaken by medical practitioners that could be safely performed by other health professionals in appropriate settings. Such research would improve patient flow in in-hospital settings and staff satisfaction across all disciplines. It would also result in public health savings by ensuring highly-trained, more expensive doctors spend maximal time working at the top of their scope rather than on tasks that could be safely and more cost-effectively completed by other health professionals. This would be a better focus for government reforms.

- **Additional views: The broadest range of views will give the review a thorough foundation on which to consider new policy and regulation. Please share with the review any additional comments or suggestions in relation to scope of practice.**

AMA Queensland urges the review to consider the extensive materials published on our Stop North Queensland Pharmacy Pilot campaign page in addition to this submission and that of our Federal AMA body. Both the UTI pilot and now-state-wide North Queensland pilot pose grave threats to patient safety and highlight the risks associated with ill-conceived scope expansions that are not based in evidence.

Extensions to scope are not the silver bullet to the various challenges facing the future of our health care system, including workforce undersupply and patient access. State, territory and the Australian governments must work together to ensure reforms centre patient safety as their guiding principle and current ad-hoc, unilateral and dangerous expansions immediately cease.