THE PHYSIOTHERAPY PRESCRIBING PATHWAY

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Proposal for the endorsement of registered physiotherapists for autonomous prescribing

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FOREWORD

Physiotherapy in Australia

The physiotherapy profession in Australia is comprised of a number of key stakeholders:

- the **Australian Physiotherapy Association (APA)** is the profession's peak body representing the interests of Australian physiotherapists and their patients and provides leadership, advice and support to over 18 000 members
- the **Australian Physiotherapy Council (APC)** oversees the guidance, development and assurance of standards for physiotherapy practice
- the **Council of Physiotherapy Deans of Australia and New Zealand (CPDANZ)** provides leadership and advice on policy, standards and related matters concerning entry-level and postgraduate physiotherapy education, research and knowledge advancement
- the **Physiotherapy Board of Australia** regulates Australia's physiotherapists with the support of the Australian Health Practitioner Regulation Agency (AHPRA) within the National Scheme.

Together, the APA, APC and CPDANZ represent the interests of physiotherapists and their clients in Australia. Working in partnership with the Physiotherapy Board of Australia, these organisations seek to improve standards and ensure a highly skilled and capable workforce and are proud of the physiotherapy profession's role in providing better care for Australians.

APA strategic objectives

The APA's **strategic plan** provides the opportunity to create the next building block for better access to physiotherapy in Australia. The plan is based on the three strategic objectives of Quality, Voice and Community, all underpinned by our Capability.

Quality—the APA will provide members with access to the highest quality knowledge, resources and research that keeps members skills current and relevant. The APA will remain the organisation of choice for quality professional development products and services.

Voice—the APA will continue to advocate for physiotherapy to have a broader role in healthcare. Key audiences need to know that physiotherapy can make a contribution to the health and wellbeing of the community.

Community—the APA will position the physiotherapy brand to all consumers, other health professionals and the community.

Capability—the APA will continually evolve to build the success and sustainability of the profession. We will create and maintain a compelling member value proposition that is contemporary, relevant and scalable.

Aligning with the APA's strategic objectives, healthcare services must focus on improving the consumer experience, and must be safe and more effective than the current way of doing things, at an equivalent or lower cost. In Australia, it is important that we work to redress health inequality between Aboriginal and Torres Strait Islander peoples and other Australians.

The APA believes that endorsing the registration of appropriately credentialled physiotherapists to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine within their scope of practice would be a significant step in delivering modern, consumer-centred and better value healthcare.

EXECUTIVE SUMMARY

This submission proposes reform to tackle one of the significant challenges our healthcare services face–how consumers receive their medicines–and sets out the benefits of physiotherapist prescribing of medicines for the consumer, the health system and the economy.

Current prescribing pathways are outdated, inefficient and inequitable. Many consumers currently face unnecessary circular referral between health professionals to receive the medicines they need. General practitioners' (GPs) and medical specialists' time is consumed by managing prescriptions which could be safely managed by physiotherapists, and Aboriginal and Torres Strait Islander and rural and remote communities are disadvantaged under the current arrangements.

Existing regulatory frameworks can begin to address these problems. The **Health Practitioner Regulation National Law Act 2009** (the National Law) is designed to promote innovation and reform. It allows for the endorsement of registered health practitioners to prescribe medicines, which would enable appropriately qualified and experienced physiotherapists to autonomously prescribe medicines within their scope of practice.

The physiotherapist prescribing pathway proposed in this submission would see the timely access to medicines for consumers as part of an integrated and multidisciplinary model of care.

Empowering physiotherapists to deliver safe, appropriate and timely care to patients by extending prescribing responsibilities:

- ensures consumers have appropriate and timely access to the medicines they need
- improves consumers' satisfaction and the quality, efficiency and continuity of care
- supports safe and efficient delivery of health and wellbeing services, and can improve transition from acute to community care
- decreases unnecessary use of medicines
- results in savings of $9.2 million to consumers and the health system and additional broader economic savings to government, individuals and employers
- reduces avoidable admissions to hospital and promotes lower cost community care
- promotes a sustainable, more flexible and responsive health workforce
- makes the best use of practitioner skills to maximise consumer access to physiotherapy
- promotes workforce recruitment and retention strategies, thereby facilitating access to physiotherapy services
- reduces the number of GP and medical specialist appointments
- reduces costs for compensable bodies, which can be passed on to businesses and consumers.

Recommendation

The APA recommends that the Physiotherapy Board of Australia apply to the Australian Health Workforce Ministerial Advisory Council for approval to endorse the registration of appropriately credentialled physiotherapists to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines related to their scope of practice.

Glossary of terms

AHPRA	Australian Health Practitioner Regulation Agency
APA	Australian Physiotherapy Association
APC	Australian Physiotherapy Council
AMA	Australian Medical Association
BNF	British National Formulary
CPDANZ	Council of Physiotherapy Deans Australia and New Zealand
ED	Hospital emergency department
ESP	Extended scope physiotherapy
GP	General medical practitioner
HCPC	Health and Care Professions Council (UK)
HPPP	Health Practitioners Prescribing Pathway
HWA	Health Workforce Australia
NEAT	National Emergency Access Target
MBS	Medical Benefits Scheme
NMP	Non-medical prescribing
PBS	Pharmaceutical Benefits Scheme
RPBS	Repatriation Pharmaceutical Benefits Scheme
PGD	Patient Group Direction
PSD	Patient Specific Direction
The National Law	Health Practitioner Regulation National Law Act 2009

THE CASE FOR REFORM

The APA recognises the significant challenges facing our healthcare system and the need for wide-ranging reform. Healthcare providers are challenged to efficiently deliver equitable care to all Australians, particularly to people in rural and remote regions, to older people, and to the vulnerable and disadvantaged. These members of our communities often have poorer health and rely more on publicly funded healthcare.

Safe, timely and efficient access to medicines for Australian communities can be improved by physiotherapist prescribing.

Reform of prescribing responsibilities must respond to:

- **the challenges consumers face under the current prescribing model**—how do we provide valued care, respond to the burden of chronic disease, and adapt services to our changing population and health disparities?
- **government strategy and legislation** —what are the government's priorities and which legislation shapes reform?
- **the sustainability of healthcare services** —how do we provide value for money, maintain a skilled health workforce, and mitigate any risks?

The Australian health reform agenda seeks to address these challenges

Government strategy and legislation provides the setting for reform of the current prescribing pathway and presents a means to address the challenges facing our healthcare system.

The Australian government began reforms in 2013 to streamline services, reduce duplication and red tape, and improve the efficiency of the economy.

The 2014–15 budget[1] promised expanded activity in the key areas of child and maternal health, and the prevention and management of chronic disease. The Australian government also reinforced its commitment to delivering effective and efficient health services for Aboriginal and Torres Strait Islander peoples.[2 3]

The 2014–15 budget also announced the establishment of Primary Health Networks (PHN) to increase the efficiency and effectiveness of medical services for patients, particularly for those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time, delivered by the right person.[4]

The current regulatory framework exists to support change

The National Law provides a nationwide regulation and accreditation scheme for health practitioners. It protects the public by setting out standards and policies that all registered health practitioners must meet.

The National Law is also designed to bring about innovation and reform in the public's interest and sets out objectives and guiding principles to:

- facilitate access to services provided by health practitioners in accordance with the public interest
- enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The National Law provides for these objectives in Section 14,[5] which sets out the process for approval of endorsement in relation to scheduled medicines. Additionally, Section 94[6] provides a mechanism for a registration board to endorse a registered health practitioner to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines.

Authorised prescribers are currently limited to medical practitioners, dentists, optometrists, midwives and nurse practitioners.

Other legislation will require amendment. As noted by the Podiatry Board of Australia:

> *Although the endorsement for scheduled medicines indicates a podiatrist is qualified to administer, obtain, possess, prescribe, sell, supply or use the scheduled medicines listed in the National Podiatry Scheduled Medicines List, it does not authorise the podiatrist to do so. Authorisation to use scheduled medicines is provided for under the relevant drugs and poisons legislation in each State and Territory...*[7]

The Pharmaceutical Benefits Scheme (PBS), Repatriation Pharmaceutical Benefits Scheme (RPBS) and other state and territory legislation will require amendment to fully effect the change consumers need.

The PBS and RPBS have a regulatory role in prescribing because they allow only authorised professions to prescribe listed medications.

In addition, each state and territory has legislation that regulates the possession, manufacture, use and supply of scheduled substances, which include medicines. State and territory governments restrict prescribing by using classifications in the Poisons Standard 2009.[8]

We acknowledge the need for reform of other legislation and regulation; however, this submission is solely concerned with endorsement of physiotherapists to prescribe according to the provisions of the National Law.

Physiotherapists are well positioned to take a greater role in prescribing

Physiotherapy has been a primary contact profession in Australia for nearly 40 years. A referral from a GP or other healthcare practitioner is not required to visit a physiotherapist.

Consumers recognise this expertise, and APA research shows that 71% of privately funded physiotherapy consumers are not referred by their doctor, but have autonomously chosen to visit their physiotherapist.

GPs understand that physiotherapists are experts in treating musculoskeletal conditions, with GPs referring more consumers to physiotherapists than any other single group of health practitioners.[9]

Physiotherapists prevent, diagnose, assess and treat disease and disability in all areas of the body. Consumers access physiotherapists across diverse clinical settings in the public and private sectors and their scopes of practice, experience and qualifications make them key autonomous health practitioners and valued members of multidisciplinary teams.

They work to optimise body function, activity and participation of their clients by addressing impairments, activity limitations and participation restrictions. Their patient-centred practice is founded on their ability to clinically analyse, reason and problem-solve in a biopsychosocial context.

As primary healthcare providers, physiotherapists focus on wellness and avoiding more expensive interventions.

For example, diabetes, chronic pain, asthma and arthritis are four common long-term conditions whose treatmentby physiotherapists, as part of a primary healthcare team, can help avoid acute deterioration in people living with these conditions and prevent more costly hospital admissions.

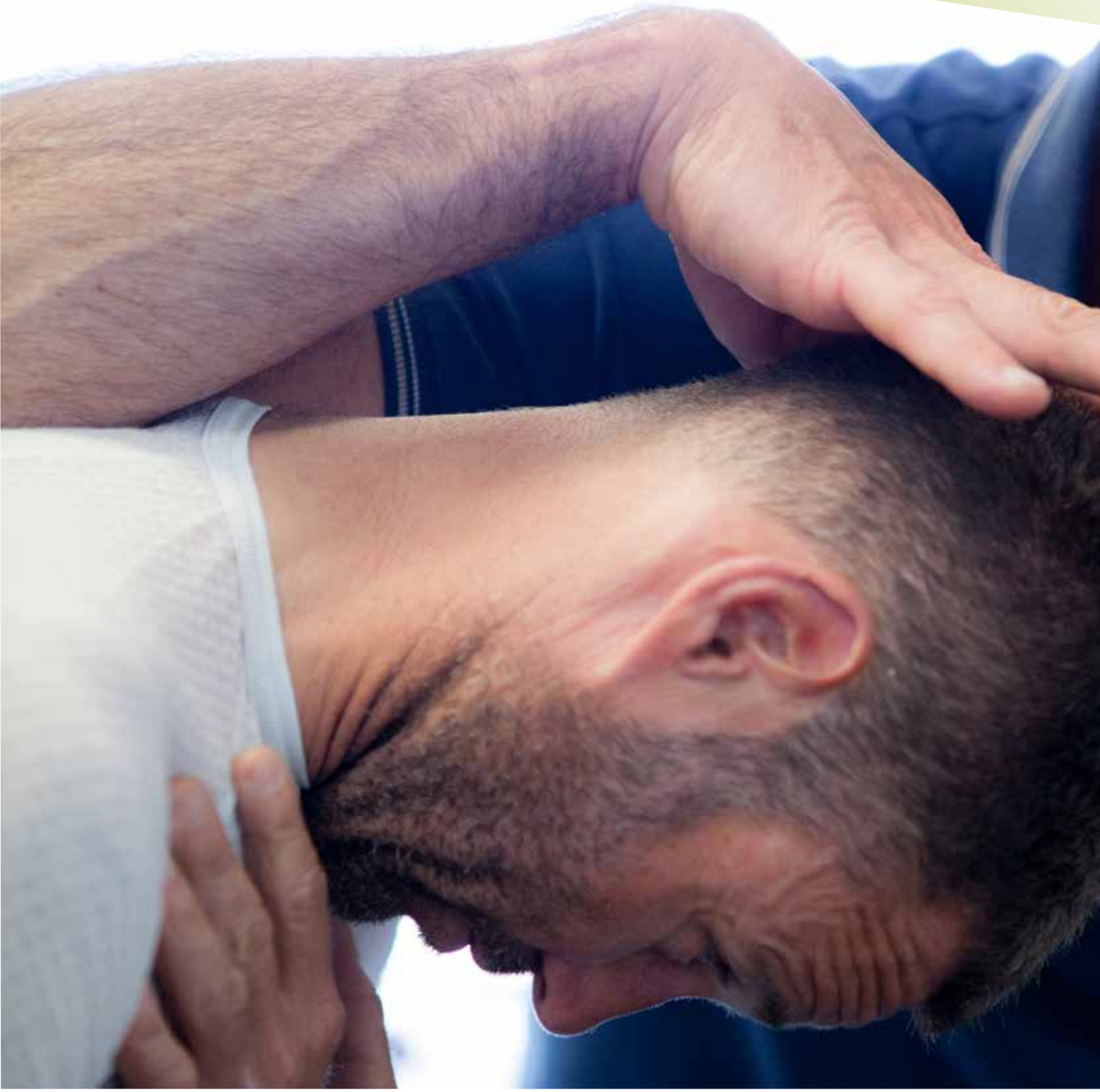
Physiotherapists assist people who are at risk of developing or have a chronic disease, to safely optimise their level of physical activity. They also help people with chronic diseases to safely and effectively manage their own care.

Being primary contact professionals with excellent communication skills, physiotherapists are accessible to members of their local community. They are well placed to promote physical activity guidelines and healthy lifestyle.

In community care settings, physiotherapists prescribe and implement therapeutic exercise alongside other physiotherapeutic techniques and treatment modalities for groups and individuals, and lead exercise and education classes for people who have been diagnosed with or are at risk of developing chronic diseases.

In this way, physiotherapists help people manage their own care and reablement so they can participate in their communities.

In hospital settings, physiotherapists provide inpatient and outpatient care to people with acute and chronic respiratory conditions, temporary and long-term disabilities, musculoskeletal and neurological conditions, and for patients before and after surgery.



THE IMPACT OF CURRENT PRESCRIBING PROCESSES ON PATIENT OUTCOMES

In hospitals and the community, funding streams, red tape, legislative barriers and workplace culture create fragmented care and add cost, complexity and duplication to the consumer journey–and delay recovery.

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It is widely acknowledged that consumers face unnecessary 'toing and froing'[10] or a 'referral loop'[11] to get the treatment they need.

Consumers often have to access a range of allied health and medical specialists to achieve the best possible health outcomes, so health practitioners sometimes develop practices to work around the administrative barriers.

'Work arounds' put consumers at risk

Health practitioners often find pragmatic ways of making an inefficient system work for the benefit of the consumer. However, as the Australian Medical Association (AMA) points out, 'ad hoc practices and approaches to education, practitioner competence and prescribing practices are a risk to consumer safety'.[12]

In its 2015 survey of physiotherapists, Deloitte Access Economics asked respondents to provide examples of ways in which the system was 'worked around' to reduce impacts on patient care.

Work around measures included forming trust relationships with a prescriber. In some instances the prescriber simply took a verbal account of the consumer's situation and signed the prescription without seeing the patient.

Other respondents suggested that the consumer try over-the-counter medication as a temporary measure while waiting for a GP appointment, and providing GPs with very clear advice on the prescription required.

Some respondents further noted that at times they had relied on past prescriptions the consumer had received for pain management for other injuries. Finally, depending on the clinical setting, some asked others within their clinic who were eligible to prescribe, including podiatrists, specialists and GPs, to provide a prescription.

CASE STUDY

Chronic back pain in the outpatient setting

Blake is 45 and has a long history of back pain. Originally his pain started when he lifted a heavy box. He usually manages his back pain with exercise, staying active and daily use of paracetamol, which he buys at the supermarket.

Every so often Blake's pain is so severe he can't move. Although his GP has taught him how to manage his pain, he often attends his local ED. Blake's pain means that he is often off work.

Blake's GP is finding it increasingly difficult to help him with his pain and decides to refer him to the local physiotherapy-led spinal assessment service. Blake is thoroughly assessed and appropriately investigated by an experienced advanced practice physiotherapist.

The service determines that Blake doesn't need surgery and identifies the need for a coordinated biopsychosocial approach to manage his condition.

The physiotherapist begins cognitive behavioural input immediately and recognises Blake will also need exercise therapy and more manual interventions. He'll also need a review of his pain medication for the quickest and most effective outcome.

As legislation does not allow for his physiotherapist to prescribe, Blake needs to see his GP for the prescription medications recommended by the physiotherapist.

Following his spinal assessment, Blake feels motivated and immediately books an appointment to see his GP. Fortunately, he manages to get a cancellation appointment in three days' time, but by the time Blake gets to see his GP his pain has flared up once again and he has lost his motivation to actively manage his pain.

After several more months the GP decides to refer Blake to the hospital pain management clinic on the other side of the city. After a three-month wait, Blake sees the multidisciplinary team including a medical specialist and the same advanced practice physiotherapist.

At the pain management clinic Blake is assessed by both the medical specialist and advanced practice physiotherapist. Blake is started on a trial of new medication, which is agreed on by the team and will help him to do his rehabilitation.

Blake has been unable to work during his long wait for treatment and now feels depressed. His psychological state is also making his pain worse. The pain management team recognise Blake's depression and refer for additional therapy from the clinical psychology team working alongside them.

Had the physiotherapists been able to prescribe the medication recommended initially, Blake may have been able to return to work earlier and may not have needed the referral to the specialist pain clinic, possibly avoiding the need for psychological treatment for clinical depression.

Rural and remote Australians have inequitable access to medicines

Australians living in remote or very remote areas[13] have, on average, higher rates of risky health behaviours, such as smoking; poorer access to health services, and worse health than people living in regional or metropolitan areas.

This could be due to distance or sub-optimal access to services, the lower socioeconomic status of people who live in remote areas, or the higher proportion of Aboriginal and Torres Strait Islander peoples who live in remote areas—or a combination of all three.[14]

Rural and remote areas also face a shortage of secondary care practitioners. Consumers requiring specialist medical care must often travel for hours and have the additional costs of accommodation and time off work. Consumers may delay specialist appointments, or simply fail to attend. In some circumstances, the effect may be inconvenience or additional fees for consumers; however, people in rural and remote areas may be subject to greater delays and suffer health issues associated with delayed treatment.

A delay in care risks aggravating acute conditions and developing a chronic condition that would otherwise have been resolved through appropriate management; or it may mean that a chronic condition is poorly managed or remains undiagnosed, resulting in a hospital admission that could have been avoided.

Aboriginal and Torres Strait Islander peoples' health inequities are exacerbated

The APA is committed to closing the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and other Australians, within a generation. The APA is a member of the **Close the Gap campaign**, which is built on evidence that significant improvements in the health status of Aboriginal and Torres Strait Islander peoples can be achieved within short time frames.

Aboriginal and Torres Strait Islander peoples have shorter life expectancy, higher rates of chronic and preventable illnesses, poorer self-reported health, and a higher likelihood of being hospitalised than other Australians.[15]

There are substantial inequalities between Aboriginal and Torres Strait Islander peoples[16] and other Australians, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectancy.[17]

Aboriginal and Torres Strait Islander peoples in rural and remote regions face lower levels of access to publicly funded primary health and are being admitted to hospital for treatment of chronic diseases like diabetes, which would be better treated within a primary healthcare setting.[18] Preventable hospitalisations for Aboriginal and Torres Strait Islander peoples living in remote areas represent a higher proportion of all hospitalisations (39%) than nationally (26%).[19]

Currently, access to medicines is provided in certain circumstances to people in rural and remote locations through special arrangements that include Aboriginal and Torres Strait Islander health workers and remote area nurses. Aboriginal and Torres Strait Islander peoples in particular need strategies to increase access to health services, including improved access to and quality use of medicines, and legislative reform[20] alongside improvements in behavioural and social factors.[21]

This population would benefit from a physiotherapist endorsed to prescribe medication within their scope —every touch-point with a health practitioner is an opportunity to redress the effects of reduced access to healthcare experienced by all peoples in rural and remote areas of Australia.

CASE STUDY

Physiotherapy prescribing improves the life of a rural mother with a disability

Diane lives in a small, remote community in Wales. Diane has multiple sclerosis, which causes neurological damage resulting in the development of muscle spasticity—an excessive contraction of the muscles.

Her condition means her medications need to be modified frequently and in a timely manner. Her management consists of splinting, exercise and injections, which when well-coordinated help to maintain function and quality of life.

Diane experiences significant pain, loss of movement in her joints, decreased function and pressure sores. She relies heavily on her partner, Mike, who is finding it very difficult to hold down his full-time job and to care for Diane and their two children.

Diane's physiotherapist is her primary healthcare provider but when her condition worsens, Diane is referred to the consultant-led spasticity services at Neath Port Talbot Hospital. This service improves the integration of physical and medical management for people with long-term neurological conditions to improve quality of life, to increase independence, and to reduce pain and hospital admissions.

The trip to Neath Port Talbot Hospital is a 260km, six-hour round-trip, and costs about A$110 in petrol. Diane's disability means that she can't drive herself so Mike needs to take a day off work for each appointment. Mike has used up his leave and now has to take unpaid leave.

At the hospital, Diane receives botulinum toxin (Botox®) injections, a medications review and then her physiotherapy treatment. Only the medical specialist can prescribe Diane's Botox, and only then can she visit the physiotherapy department for the injection from the physiotherapist as part of their intervention.

Diane's local physiotherapist is heavily involved in the assessment process and, until her referral to the hospital outpatient service, had provided the majority of her care. Diane begins to ask why her physiotherapist couldn't provide the injections closer to home, where she usually receives her physiotherapy.

As a result of her enquiries, the local health board designs a local physiotherapy-led spasticity management service covering Diane's village. Diane's physiotherapist undertakes the appropriate credentialling to prescribe the medication Diane requires, and her treatment continues close to home.

Now Diane no longer has to wait to see the specialist for the Botox® prescription and injection, or physiotherapy assessments and treatments at the hospital. Diane's local physiotherapist can now inject the Botox® at Diane's home and then provide electrical stimulation, splinting and exercise as part of a holistic and timely program. Diane now shares the decision-making with her local physiotherapist to implement the right treatment program at the right time.

Mike no longer has to take time off work for long trips for treatment, and because Diane doesn't have to wait as long for her treatment, she maintains function and has an improved quality of life. She can look after herself and share parenting with less help from Mike.[65]

Hospital demand levels and waiting times are increased

The National Health and Hospitals Reform Commission Report[22] identified the challenges facing Australia:

- large increases in demand for healthcare
- equity of access for all Australians
- financial sustainability of the system
- workforce shortages
- a fragmented health system.

The report recommended that the roles of health practitioners be expanded to address growing demand.

Within hospitals, the efficient operation of an emergency department (ED) is crucial for improving the consumer experience and health outcomes.

The Monaghan Review in South Australia showed that the efficient functioning of the ED, and therefore the most effective treatment of patients, was 'a whole of hospital issue, and indeed more broadly still, a whole of system issue, including community based care and inter-hospital systems.'[23]

Inclusion of physiotherapy services in hospital EDs has been shown to improve consumer satisfaction and the quality, efficiency and continuity of care.

In 2014, **Health Workforce Australia (HWA)** published the final report of the Extended Scope of Practice Programme Evaluation: Physiotherapists in the Emergency Department Sub-project.[24]

The report concluded that when primary contact physiotherapists were on shift in the ED, National Emergency Access Target (NEAT)[25] performance and consumer through-put were improved. Waiting time and total time spent in the ED by patients was also lower on these days.

Studies at the Bristol Royal Infirmary in the UK examined the effect of deploying extended scope physiotherapists on consumer satisfaction and the effect of the delay in physiotherapeutic input caused by waiting for medical and nursing staff to prescribe and administer medications in the ED.

The extended scope physiotherapy (ESP) service achieved consumer satisfaction that was superior to either emergency nurse practitioners or doctors.

Overall, 55% of consumers seen by extended scope physiotherapists strongly agreed that they were satisfied with the treatment they received, compared with 39% for emergency nurse practitioners and 36% for doctors.[26] Physiotherapists with extended skills successfully managed consumers with soft tissue injuries and achieved clinical outcomes that were equivalent to routine care by doctors.[27]

This evidence demonstrates that implementing the recommendations on current and evolving clinical practice in the National Health and Hospitals Reform Commission Report can benefit consumers and hospitals.

CASE STUDY

Chronic whiplash leads to an unnecessary hospital admission

Sarah is 27 and was involved in an accident four months ago. After the accident she was diagnosed with whiplash and told to take some paracetamol and the problem would go away. Since the accident, Sarah's pain has come and gone several times but one morning she wakes up and immediately feels neck pain, which gradually worsens.

Sarah rings to book an appointment at the local GP practice, but the next available emergency appointment isn't until later in the afternoon so Sarah decides to go to the nearest ED.

At the ED she is appropriately triaged to the physiotherapy team who are experts in the assessment and treatment of spinal problems. Unfortunately, Sarah is in too much pain to be adequately assessed and needs painkillers before the physiotherapist can examine and treat her.

Sarah has to wait for a prescribing health practitioner because other patients with more severe injuries have priority. In this time, Sarah's symptoms deteriorate and she is admitted to the ward overnight because the pain is limiting her movement and function and she cannot look after herself at home.

Sarah's stay is longer than necessary and blocks hospital beds, which would have been better used by other patients. The psychological effect for Sarah is also significant and she needs further outpatient visits to the pain management and physiotherapy teams.

In an ED where physiotherapists prescribe, an advanced care physiotherapist would assess Sarah and provide her with adequate pain medication immediately. This would be done with a holistic approach in the management of her neck pain. The physiotherapist would quickly address Sarah's biopsychosocial issues and combine complex physical and psychological interventions, discharging Sarah home and back to work with a follow-up physiotherapy plan in place.

MEETING CONSUMER AND HEALTHCARE NEEDS

Healthcare must provide services that consumers want and value. Valued services are patient centred, improve the quality and safety of care, reduce costs and improve efficiency, and most importantly improve the consumer's outcome.[28]

While there are examples of good practice, much current practice does not meet consumer's needs or promote the best outcomes, and current practice is not always the most cost-effective use of resources.

Consumer-centred care can be improved by physiotherapy prescribing

In 2012, HWA commissioned research into consumers' opinions on prescribing by health practitioners other than medical practitioners. The research sought to understand consumer:

- experiences of having medicines prescribed to them
- expectations of prescribers and their qualifications and competencies
- attitudes towards prescribing by other health practitioners
- reactions to various other health practitioner prescribing scenarios.

The research found that there is an expectation that the health practitioners prescribing medicines, regardless of their practitioner background, will be:

- knowledgeable about their consumers' medical condition and medicines
- appropriately qualified and legally allowed to prescribe medicines
- prepared to spend time with the consumer and to consider alternatives to medicines[29]

In 2014, HWA led further research into the effects of extended scope of practice including prescribing by health practitioners other than medical practitioners. The research investigated physiotherapy triage of consumers with musculoskeletal conditions presenting to the ED, and some test sites included limited prescribing of medication, the provision of local anaesthetic joint injections, and referral and discharge of consumers.

Of the 14 512 consumers treated by physiotherapists in the HWA project, 93% were discharged within four hours, compared to less than 75% for similar patients seen by other practitioners.

Patients also waited on average 30 minutes less, had shorter treatment time and their overall length of stay was reduced by 70 minutes. Most importantly, the trial found consumers reported good experiences and high levels of satisfaction with the care they received and the time it took to be seen by the physiotherapists.[30]

Legislation prevented a number of test sites from prescribing medication; however, the report noted that the lack of physiotherapy prescribing privileges was a key barrier to faster patient turnaround in the ED in those sites.

These research projects indicate that prescribing reforms can provide the services that consumers want and deliver patient-centred care. They also demonstrate that better utilising the skills of healthcare providers can improve consumers' health outcomes, satisfaction with the service and organisational performance.

Cost savings will flow to the health system and consumers through physiotherapy prescribing

Innovation and reform must provide value for money for the consumer and taxpayer so that healthcare services are sustainable.

Currently in Australia, legislative and cultural barriers only allow physiotherapists to add a proportion of the increased value of which they are capable.

In the UK, prescribing by physiotherapists has a significant role in reducing avoidable admissions to hospital and in promoting the delivery of physiotherapy services in community settings.[31 32 33]

This model often has a lower cost for treatment. This is especially true when the alternative is hospital care.

Reform also needs to strengthen the recruitment and retention of physiotherapists. A failure to recruit and retain physiotherapists reduces the capacity of the system to provide valued services and lowers the quality of care, ultimately impacting on the care of health consumers.

Reform brings with it risks as well as benefits. These risks must be addressed through a transparent training and credentialling process that ensures consumers have access to safe and effective prescribing health professionals. Health Workforce Australia's (HWA) Health Professions Prescribing Pathway (HPPP) aims to achieve this goal.

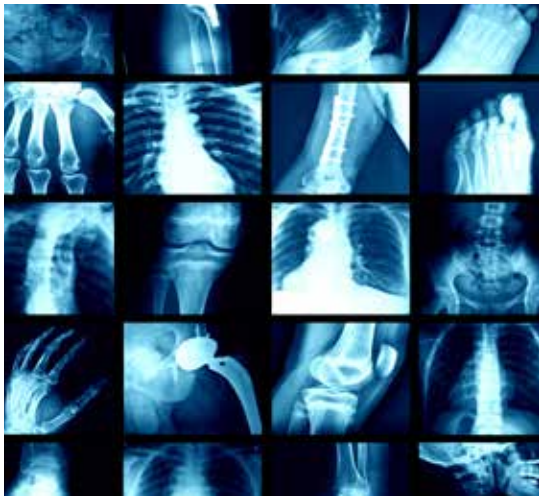
Experience from the UK demonstrates that creating pathways that allow appropriate care to be delivered more cost-effectively initiates savings across the healthcare system.

Evidence supports physiotherapy prescribing

Non-medical prescribing (NMP) in UK hospitals has reduced the length of hospital stays and increased the number of consumers treated.

Staff costs have decreased because the need for medical cover is less.

Fewer consumers need further investigations, such as X-rays, and the costs of unnecessary investigations, transport, administration and staff escorting, for example, have gone down.



Furthermore, different prescribing models have reduced the duplication of care because a consumer does not have to see another practitioner, or another service, to get the medicine they need.[34 35 36]

At Bolton Primary Care Trust, the physiotherapist-led musculoskeletal service found that while only 3% of consumers needed new prescriptions, 49% required modification of their existing medicines regime. This comprised 11% who required modification of their existing dose or preparation to improve therapeutic effect, 37% who needed modification or removal to stop medicines misuse—including 2% to stop dangerous misuse—and 1% who needed the removal of medicines to improve care.[37]

Physiotherapy self-referral pilots in the UK indicate that only 25% of consumers who self-referred needed a prescription for medicines for their condition, and prescribing physiotherapists often alter or stop existing medications and less frequently prescribe new preparations.

This saving was compounded by less use of GP time, less use of prescriptions and earlier presentation resulting in fewer contacts per episode of physiotherapy care.[38] This suggests that there is potential for large reductions in GP appointments for self-referred consumers.

If the UK experience can be translated to Australia, further savings can be achieved to the PBS, RPBS and MBS. For example, a prescribing physiotherapist treating a consumer with back pain or shoulder pain will have many different evidence-based alternatives to medicines at their disposal to be used without or in combination with medicine: postural re-education, stretching or strengthening exercise, manual therapy or manipulation, hydrotherapy, cardiovascular fitness programs, motivational interviewing and cognitive behavioural therapy. It follows that they may need to institute pharmaceutical treatment less frequently than other practitioners who may not have the other methods at their disposal.

CASE STUDY

Physiotherapy prescribing for a faster return to work

Dale is a 52-year-old mechanic. While working under a car, Dale feels a sudden sharp pain in his shoulder. His employer immediately reports a workplace injury to Worksafe, and sends Dale to his local GP for assessment and treatment. He is diagnosed with a muscle sprain and sent to a private physiotherapist, paid for by his workers' compensation insurance.

Dale goes to the physiotherapist immediately, but is in so much pain that he can't move his shoulder or be touched. Because of the pain, the physiotherapist can't make an accurate assessment, so sends Dale back to the GP for prescription pain relief. The GP prescribes anti-inflammatory medication and requests a diagnostic ultrasound. The medication doesn't help the shoulder and the ultrasound results aren't helpful for Dale's injury, so the GP refers him for an MRI and to an orthopaedic surgeon. The GP also prescribes additional pain medication and anti-inflammatories. The MRI shows an acute bursitis, and Dale is left to wait for over a month to attend his specialist appointment. During this time Dale cannot work due to the pain in his shoulder, and is receiving income replacement from Worksafe of around $2000 per week.

When Dale sees the orthopaedic surgeon, he is told that his condition is not suitable for surgery, and the surgeon sends him back to the physiotherapist for conservative treatment. The wait has meant that Dale has been off work and unable to move his shoulder for eight weeks.

The physiotherapist starts treatment for the bursitis, but the wait for treatment and fear of moving his shoulder means that Dale has now developed frozen shoulder and additional neck problems. This requires ongoing physiotherapy and absence from work, followed by a return to work on modified duties. His conditions take over a year to fully resolve.

If Dale's physiotherapist were able to prescribe appropriate analgesia at his first consultation, his chronic conditions could have been avoided. The physiotherapist could have done a thorough assessment and provided a quicker diagnosis for a faster return to work, at a significantly reduced cost to Worksafe.

CREATING AND MAINTAINING A SUSTAINABLE WORKFORCE

A sustainable health system recruits and retains enough appropriate staff to meet the needs of consumers. The Australian health system has long struggled to recruit and retain staff. A failure to recruit and retain staff reduces the capacity of the system to provide services and impacts the quality of care.

The healthcare service must 'create a sustainable health workforce and work towards establishing effective planning, education and training, and retention strategies.'[39]

Extending prescribing responsibilities to physiotherapists will help address health workforce issues, ultimately leading to a better and safer experience for the consumer.

Physiotherapist prescribing will attract and retain physiotherapists

The reasons for any person deciding to stay in a position or to leave to pursue other job opportunities are complex and individual, but one factor is the opportunity for personal fulfilment and career progression.

The APA's InPublic 2025 survey asked public sector physiotherapists about the impact on physiotherapy services of limited career pathways, regional workforce shortages, and problems retaining experienced clinicians: 65.8% of respondents noted that the effect of a limited career pathway has a 'large' to 'major' impact on current physiotherapy services.

Physiotherapy prescribing will increase workplace flexibility and capacity by drawing on growing skills.

In this way, physiotherapy prescribing will promote a career pathway that encourages physiotherapists to remain where they can work to the full extent of their skills, both geographically and clinically, and provide opportunities for personal fulfilment and career progression.

Better recruitment and retention reduces a range of other direct costs, such as those associated with hiring and training, and a range of indirect costs, such as lost productivity and reduced morale associated with increased workload. These indirect costs in particular can contribute to a higher turnover of staff as dissatisfaction with working conditions builds.

Consumers benefit from a more stable physiotherapy workforce through greater continuity of care and better access to more experienced clinicians.

CASE STUDY

A physiotherapist's experience –Isle of Lewis, Scotland

Innes Morton is the extended scope physiotherapist working at the Western Isles Hospital in Stornoway on the Isle of Lewis, off the coast of Scotland. He has noticed a dramatic change to his practice since qualifying from the University of Stirling as an independent prescriber

'This has had a big impact on my practice, especially in a remote setting such as the Hebrides.'

The small physiotherapy service carries out musculoskeletal triage to identify those who require surgical interventions and those who require conservative management, including musculoskeletal injection therapy. Innes also provides patients with pre-operative pain relief.

'Because we are a bit of an outpost, people expect what we offer here to be limited. But we strive to offer the best service possible and reduce waiting times. That is why I took the independent prescribing course, because as a primary contact clinician, if I see someone who needs their pain medication changed, I can now make that decision straight away.'

Innovations like these create efficient and effective clinical interventions for patients who would otherwise have long and expensive journeys to the mainland for treatment.[66]

THE ECONOMIC CASE FOR PRESCRIBING

The APA commissioned Deloitte Access Economics to analyse the economic cost savings that physiotherapist prescribing could realise for government.

The analysis considers both accounting costs, such as an avoided GP visit that reduces the MBS rebate, and opportunity costs, such as the cost of time spent writing a script instead of treating other consumers.

The analysis takes into account the cost savings to government across the four practice settings:

- public hospital ED
- public hospital inpatient department
- community healthcare (including public outpatient departments)
- private practice.

Other costs, such as those to the economy because of time off work either through lengthier illness or the time needed to attend appointments, were outside the scope of the analysis.

The cost to the consumer, for example, is reduced because they take less time off work, spend less on travel, and have lower out-of-pocket expenses associated with visits to multiple practitioners. The total potential economic benefit could be significantly greater than reported.

The potential costs of physiotherapist prescribing

The groups most affected by the costs of implementing physiotherapy prescribing are physiotherapists and those responsible for governance of the profession.

Physiotherapy prescribing would require education to fulfil requirements. Physiotherapists already elect to undertake further education on a voluntary basis, which incurs costs, and prescribing education would also follow this model.

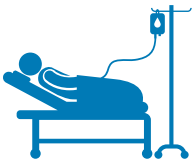
Physiotherapists would also incur the cost of the time to attend educational programs.

Some physiotherapists' education is funded under individual workplace arrangements for practitioner development and would be part of existing costs.

Entities involved in the governance of prescribing physiotherapists would also incur a cost to develop and administer governance arrangements. The regulator's costs are generally recouped in registration fees.

THIS YEAR **IN PUBLIC HOSPITALS:**

14,357
patients in ED
will need a script as part of their assessment and treatment by a physiotherapist



92,383
inpatients
will need a script as part of their physiotherapy assessment and treatment

The equivalent of one nurse practitioner will
spend six
working weeks
in ED prescribing on behalf of physiotherapists

14 ED doctors will spend
a month
of their year
at work writing scripts on behalf of physiotherapists

100 doctors
will spend four working weeks
simply writing scripts on behalf of physiotherapists

650 public sector
physiotherapists
will spend this working week waiting for scripts for their patients

200 nurse practitioners
in in-patient departments
will spend today
writing prescriptions for physiotherapy patients

in ED, 95 physiotherapists will spend the equivalent of
an entire
working week
waiting for prescriptions for their patients before they can continue their treatment

THIS YEAR **IN COMMUNITY HEALTHCARE:**

This year, reform could **save the taxpayer over**

$1.89 million

in Medicare fees alone

1-2 million

visits to private physiotherapists alone will be caused by the 'prescription treatment loop'

51,000

patients will need a script for their physiotherapy treatment

The 'prescription treatment loop' will **cost consumers and insurers**

$64-$128 million

Public sector consumers could be **losing up to**

$5 million

this year on unnecessary visits to GPs and referral loops

2,500 GPs

won't treat patients at all today. They will spend the day writing prescriptions for the patients of physiotherapists instead

POTENTIAL SAVINGS TO **GOVERNMENT AND GENERAL PUBLIC**

Public hospital EDs

Avoided time spent by physiotherapists, doctors, nurse practitioners to handover and re-assess patients. Avoided GP visits and ED attendances by patients who are referred solely for a prescription

$422,588
(Government)

Public hospital and inpatient departments

Avoided time spent by physiotherapists, doctors, nurse practitioners to handover and re-assess patients. Avoided GP visits and ED attendances by patients who are referred solely for a prescription

$2,823,506
(Government)

Public outpatient departments and community healthcare

Avoided time spent by physiotherapists, doctors, nurse practitioners to handover and re-assess patients. Avoided GP visits and ED attendances by patients who are referred solely for a prescription

$426,580
($396,705 to Government + $29,875 to patients and PHI)

Private practice

Avoided time spent by physiotherapists, doctors, nurse practitioners to handover and re-assess patients. Avoided GP visits and ED attendances by patients who are referred solely for a prescription

$3,196,411
($2,972,534 Government + $223,877 to patients and PHI)

Private practice

Additional physiotherapy consultations in private practice

$2,354,917
(Patients and PHI)

=

$9,224,002
Total savings
($6,615,333 Government + $2,608,669 patients and PHI)

MANAGING RISK THROUGH QUALITY AND SAFETY FRAMEWORKS

One the APA's key strategic objectives centres on quality in relation to physiotherapy practice, professional development and risk management.

The potential benefits to the consumer and healthcare system of physiotherapy prescribing are considerable. However, risks need to be identified and managed to ensure that autonomous physiotherapy prescribing is sustainable. The identified risks of prescribing are the:

- misuse of medicines
- burden of extending additional governance to physiotherapists
- fragmented management of patient health records.

Mitigating risk through robust regulation and governance

Physiotherapists are registered nationally by the Physiotherapy Board of Australia and regulated by the National Law, which is enforced by AHPRA.

They are subject to AHPRA's codes of conduct, governance frameworks, workplace rules and guidelines, and APA members are also subject to the rules and codes of membership. Physiotherapists are also subject to the criminal and civil legal system.

These robust regulatory mechanisms ensure that physiotherapists only work with consumers who have conditions or injuries within their scope of practice in their current day-to-day work.

Additional elements of the regulatory framework extend to prescribing practitioners:

- **The Australian Safety and Quality Framework for Health Care** sets out principles of safe and high-quality care. Care should be:
  - consumer-centred
  - driven by information
  - organised for safety.
- **The National Strategy for the Quality Use of Medicines** guides practice by advocating the wise selection of medication management options. Quality use of medicines is based on:
  - the primacy of consumers
  - active and respectful partnerships
  - consultative, collaborative, multidisciplinary activity
  - support for existing activity
  - systems-based approaches.
- **The Prescribing Competencies Framework** promotes quality use of medicines to all prescribing professions. The framework describes the skills, knowledge and behaviours that health practitioners need to prescribe medicines judiciously, appropriately, safely and effectively.
- **The Therapeutic Goods Administration** monitors the safety of therapeutic goods outside the controlled conditions of clinical trials.
- **The Adverse Medicine Events Line** telephone service provides independent, accurate and evidence-based information for consumers, and is an avenue for reporting and discussing adverse experiences with medicines.
- **Personally Controlled Electronic Health Record (PCEHR)** will improve the safety, efficiency and effectiveness of healthcare, and digital records management. The government will redevelop the system to improve its usability and clinical utility, strengthen eHealth governance and operations, and trial new participation arrangements. The PCEHR will be renamed My Health Record and the Australian Commission for eHealth will be established to manage governance, operation and ongoing delivery for eHealth from 1 July 2016.[40]

Physiotherapists are trained to consider their own scope of practice and the need to refer the client to a different health professional during the analysis of the assessment findings, the development of an intervention plan, the implementation of the treatment plan and the evaluation of the intervention. These considerations are embedded into every part of entry-level education requirements, and into every part of a physiotherapist's day-to-day practice.

This training, coupled with the robust regulatory frameworks and advanced education in prescribing, would prevent endorsed physiotherapists from prescribing outside of their scope of practice.

Promoting safe practice through training and education

Safe and high-quality health professional practice is maintained by a framework that sets standards for education, training and practice and ensures compliance with those standards.

This framework is established by the National Law and put into effect by the Physiotherapy Board of Australia and the APC.

As regulated practitioners, physiotherapists are required by law to be registered by the Physiotherapy Board of Australia.

As part of registration they must have completed a recognised bachelor's or master's degree and take part in ongoing education and training. The responsibility for ensuring that entry-level physiotherapists meet the physiotherapy practice thresholds (in Australia and Aotearoa New Zealand) is placed in the CPDANZ and the constituent university programs.

Physiotherapists increasingly have a professional or research doctorate degree and develop clinical expertise in specialised fields of physiotherapy.

This educational pathway, supported by regulation, maintains standards, provides for improvement and ensures outcomes. This framework applies to all registered practitioners, including non-medical practitioners endorsed to prescribe.

Like all other registered practitioners, physiotherapists work within the regulatory framework that ensures quality and safe practice and the integrity of the profession. If a practitioner breaches any of their professional obligations under the National Law, it is a matter for AHPRA or the equivalent authority such as the NSW Physiotherapy Council to pursue.

If a practitioner's registration is endorsed, it means they meet the Physiotherapy Board of Australia's standards that ensure public safety and quality practice.

THE OPTIONS FOR PRESCRIBING REFORM

The Health Practitioners Prescribing Pathway (HPPP) sets out a national approach to safe and competent prescribing by health practitioners other than medical practitioners.

It was developed by Health Workforce Australia (HWA) and approved by Australia's health ministers in November 2013. The HPPP provides a range of options for prescribing that have been considered in this submission.

The HPPP addresses prescribing models, competency attainment, registration and endorsement, safety, and quality and practice issues.

It aims to improve health workforce productivity and the patient experience by safely increasing the ways people can get prescribed medicines.[41 42 43]

The HPPP describes three models for prescribing:

1. prescribing under a structured prescribing agreement
2. prescribing under supervision
3. autonomous prescribing.

Australia faces unique challenges and opportunities in implementing the models proposed by the HPPP. However, varieties of the HPPP models have been practised and developed in the UK since 1992 and provide valuable insights.

The UK experience is that non-medical prescribing in its various forms is safe and acceptable to consumers and other clinicians, and its benefits include faster access to medicines, time-savings within the National Health Service (NHS) and improved service efficiency.[44] The benefits and disadvantages from UK experience of each of the models are provided in the tables below.

The three HPPP models correspond to five models practised in the UK:

HPPP model	UK or Australian practice
1. Prescribing under a structured prescribing agreement	› Patient Specific Directions › Patient Group Directions
2. Prescribing under supervision	› Supplementary prescribing
3. Autonomous prescribing	› Autonomous prescribing with a limited formulary (prescribing by exemption from legislation) › Autonomous prescribing within scope of practice (independent prescribing)

1. Prescribing under a structured prescribing agreement

In this model, a prescriber with a limited prescribing authorisation prescribes medicines under a guideline, protocol or standing order.

A structured prescribing arrangement should be documented sufficiently to describe the responsibilities of the prescriber and the communication between team members and the person taking medicine.[45]

The UK implements prescribing under a structured prescribing agreement in two ways:

- Patient Specific Direction (PSD)
- Patient Group Direction (PGD)

Patient Specific Direction

A PSD is a written instruction, like a prescription or a note on a patient file, for a medicine to be supplied or administered to a named patient. A PSD relies on the input of an autonomous prescriber and only allows treatment of a single, named patient. A PSD does not limit those who can supply or administer the medicine. For example, a suitably trained healthcare professional can do so.[46]

The employing organisation is responsible for ensuring that staff are properly trained, and undertake only those responsibilities specified in job descriptions. Those delegating a duty must ensure that staff are competent.[47 48]

Some organisations extend or limit those who are authorised to supply or administer medicines under a PSD, through medicines policies and governance arrangements.

HPPP model	UK practice	Description	Disadvantages	Benefits
Prescribing under a structured prescribing agreement	› Patient Specific Direction	› Prescription, written or electronic instructions or note on a patient's ward drug chart from an autonomous prescriber for a medicine to be supplied or administered to a named patient	› Relies on an autonomous prescriber › Only allows treatment of a single, named patient › Those delegating the duty must ensure that the non-regulated staff are competent to do so safely › Requires locally approved procedure or guideline	› Any suitably trained health professional can treat under a PSD › Patient receives medication without delay

Patient Group Direction

A PGD is a written instruction that authorises a named, registered health practitioner to supply or administer a licensed medicine to a patient with an identified clinical condition.

A PGD must be agreed to by a doctor and senior pharmacist, and approved by the employer. The healthcare practitioner is responsible for assessing whether the patient fits the criteria set out in the PGD.

PGDs may be appropriate where assessment and treatment follow a clearly predictable pattern[49] and where there are appropriate practitioner relationships and accountability.

Although certain drugs are often excluded, for example controlled drugs, PGDs provide 'one stop' treatment in which the patient receives medication without delay, and promote consistent prescribing regardless of practitioner.[50]

PGDs are designed for short-term care, and are not usually appropriate for patients requiring multidisciplinary, ongoing care. PGDs can be slow to set up while governance systems are put in place.

UK pharmacists report concern about the additional workload associated with the purchase and stocking of prepacked and pre-labelled medication, and that there is no second-person check for the dispensing process.[51]

Under PGDs, there is little scope for exercising clinical judgement. PGDs do not allow physiotherapists to modify medication, for example by stopping one previously prescribed medication to supply another more appropriate drug, or mix medication.[52 53]

Many workplaces require different medications to be detailed on separate PGDs, with some clinical settings requiring numerous PGDs to manage a single pathology.

This pathway poses a significant barrier to patient -centred care for physiotherapy departments which do not have in place the necessary PGDs to manage certain health conditions.[54]

HPPP model	UK practice	Description	Disadvantages	Benefits
Prescribing under a structured prescribing agreement	› Patient Group Direction	› Prescription, written or electronic instructions or note on a patient's ward drug chart from an autonomous prescriber for a medicine to be supplied or administered where the patient is not individually identified	› Must be agreed by a doctor and senior pharmacist, and approved by the employer › Only authorises a named, registered health practitioner to supply or administer › Slow to set up while relevant governance is put in place › Additional workload of the purchase and stocking of prepacked and pre-labelled medication › No second-person check on the accuracy of supply and dispensing process › Not usually appropriate for patients requiring ongoing care › Unable to modify medication › No mixing of medicines › Does not allow holistic medicines management › Certain drugs are often excluded	› Patient receives medication without delay › Few restrictions on which conditions can be included in a PGD › Promotes consistent prescribing regardless of practitioner › Designed for supply and/or administration of medicine for short-term care

2. Prescribing under supervision

In Australia, prescribing under supervision occurs where a practitioner prescribes within their scope of practice under the supervision of another authorised health practitioner.[55]

In the UK, prescribing under supervision is known as supplementary prescribing.

Supplementary prescribing

Supplementary prescribing is a partnership with an independent prescriber for a named patient, via an agreed patient-specific clinical management plan. The supplementary prescriber can alter dosage, and remove or write prescriptions according to that plan.[56 57]

Supplementary prescribing is used in a broad range of community and acute settings and is used mainly for long-term conditions and continuing care.[58 59]

Under this mechanism, the medical prescriber must review a new client before the supplementary prescriber can start to prescribe, and then must continue to review them at regular intervals.

However, medical prescribers are often unavailable in many clinical settings, such as outpatient departments and in rural and remote areas. Doctor availability has been identified as posing 'the greatest challenge' for physiotherapists implementing such treatments.[60]

The dependence on a link with, and the agreement of, doctors makes this mechanism inflexible and unsuited to alternative care pathways, like the self-referral pathway, which is a particular feature of the Australian healthcare system.

This mechanism is also unwieldy when a patient is referred. The referral pool frequently includes numerous GP clinics or geographical areas so it is often not possible to develop the close individual working relationships with such a potentially large number of doctors.

This model does not satisfactorily address the effect of delays on hospital performance and patient outcomes, and supervised prescribing does not make full use of the physiotherapist's potential to add value throughout the health system. It also fails to fully support concepts of patient-centred care.

HPPP model	UK practice	Description	Disadvantages	Benefits
Prescribing under supervision	› Supplementary prescribing	› A partnership with an independent prescriber for a named patient, via an agreed patient -specific, clinical management plan. The supplementary prescriber can alter dosage, and remove or write prescriptions only according to that plan	› Doctor must review a new client before the physiotherapist can start to prescribe, and then must continue to review them at regular intervals › Doctors often unavailable for consultation in many clinical working environments › Inflexible and unsuited to alternative care pathways › Does not address systemic delays	› Used in a broad range of community and acute settings › Patient receives medication without delay › Suited to long-term conditions and continuing care

3. Autonomous prescribing

In this model, prescribing occurs where a prescriber undertakes prescribing within their scope of practice without the approval or supervision of another health practitioner.

The prescriber has been educated and authorised to autonomously prescribe in their specific area of clinical practice.

Although the prescriber may prescribe autonomously, they recognise the role of all members of the healthcare team and ensure appropriate communication occurs between team members and the person taking medicine.[61]

Both Australia and the UK have prescribing models that allow autonomous prescribing with a limited formulary, for example in Australia by podiatrists and optometrists, and in the UK by physiotherapists.

Autonomous prescribing with a limited formulary

This mechanism allows named professions to prescribe selected medications without the supervision of a medical prescriber.

However, it creates a burden for regulators in maintaining schedules of medications and extending governance arrangements but it cannot accommodate the breadth of medication needed in the self-referral pathway, and does not maximise potential benefits for the health system.

Scope of practice for the physiotherapy profession can include such diverse areas as cardiorespiratory, continence and women's health, gerontology, musculoskeletal, neurological, occupational health, paediatrics and sports physiotherapy, along with other speciality areas.

This diversity in the physiotherapy profession limits the usefulness of a prescribed formulary for the physiotherapy profession.

HPPP model	UK practice	Description	Disadvantages	Benefits
Autonomous prescribing	› Limited formulary	› Endorses specific professions to prescribe and sets out which medicines may be supplied	› Exemptions only cover a limited number of professions › Only provides for those medicines cited in the regulations › Administrative burden for the regulator in maintaining and amending the schedules of exemptions when circumstances change › Not suited to the self -referral pathway	› Patient receives medication without delay › Useful in some settings

Autonomous prescribing within scope of practice

Autonomous prescribing is a model in which the practitioner clinically assesses and diagnoses the patient and prescribes from a formulary within their individual scope of practice. The UK has further extended prescribing responsibilities to non-medical practitioners, including physiotherapists, within their scopes of practice.

The practice of physiotherapy encompasses a diversity of clinical specialties to meet the unique needs of different client groups. This means that the scope of practice of an individual physiotherapist may differ significantly from his or her peers. Therefore the formulary of medicines suitable for prescription will vary between practitioners, much as it does between differing specialist medical practitioners.

The autonomous prescriber determines the appropriateness of any prescription and manages ongoing therapy without predefined protocol, and without the requirement for supervision by another healthcare practitioner.[62 63]

Appropriately qualified and endorsed physiotherapists in the UK may prescribe any licensed medicine from the British National Formulary (BNF). They may prescribe within national and local guidelines, provided it falls within their individual area of competence and scope of practice, and within the overarching framework of human movement, performance and function.

They may also mix medicines before administration and may prescribe from a restricted list of controlled drugs (Schedule 8 medicines). If a prescriber prescribes a substance that is not within the scope of practice, it is a matter of practitioner conduct and may be investigated by the UK's health professions' regulator, the Health and Care Professions Council (HCPC). In Australia AHPRA would investigate such conduct.

HPPP model	UK practice	Description	Disadvantages	Benefits
Autonomous prescribing	› Within scope of practice	› Practitioner is responsible for the clinical assessment, diagnosis; prescribes using a formulary within their scope of practice; determines the appropriateness of any prescription; manages ongoing therapy without predefined protocol and without supervision	› Requires method of communication between practitioners	› Patient receives medication without delay › Flexible, responsive › Efficient use of health resources › Forms partnerships across practitioner and organisational boundaries › Treatment of a wide range of patients with varying needs › Suited to all settings

Autonomous prescribing will deliver the greatest benefit

Autonomous prescribing for physiotherapists within their scope of practice would significantly contribute to solving the challenges our healthcare services and consumers face, as described in this submission.

This option presents a significant opportunity to effect system-wide change that would provide cost savings to the health system and the greatest benefit to consumers,[64] improve access and choice, and reduce health inequalities.

Autonomous prescribing overcomes the dependence on doctors and makes better use of existing workforce resources. It helps form partnerships across historical practitioner and organisational boundaries and builds care pathways that are cost-effective and sustainable, for example by improving the transition from acute to community care.

It creates a career pathway for physiotherapists and provides an incentive for them to remain in the public sector and in regional and remote areas. This increases access to physiotherapy services for consumers where it is needed most.

Autonomous prescribing is the most flexible and responsive mechanism of the available options and is the mechanism that most suits the needs of patients in a self-referral pathway and in community and hospital settings.

Endorsement of the registration of appropriately credentialled physiotherapists to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine within their scope of practice would be a significant step in delivering modern, consumer-centred and better value healthcare.

Autonomous prescribing would save the health system and consumers $9.2 million each year, freeing up the time of doctors to focus on other patients, and building on the benefits of established advanced physiotherapy roles in the public sector.

Endorsement for autonomous prescribing is not new, and has already succeeded in increasing consumer satisfaction and allowing for faster medication management in the UK. While there is some history in Australia of NMP from a limited formulary, consumers would not realise the full benefit of physiotherapy prescribing under this model.

The implementation of a ridged formulary would bring with it a significant administrative burden due to the necessity of constant review to ensure that new drugs and the latest research are adopted.

Australia's health system should provide consumers with access to the medication they need, where and when they require it. Physiotherapists can improve access for all Australians, and should be utilised as autonomous prescribers within their scope of practice, to ensure that the Australia Health System is sustainable and consumer-centred, now and into the future.

A VISION OF THE PHYSIOTHERAPIST OF 2020

Chris is a physiotherapist in Far North Queensland. Legislation in Queensland allows autonomous prescribing, and consumers there are treated by highly trained generalist rural/remote physiotherapist prescribers. Chris has met all the requirements for registration by the Physiotherapy Board of Australia and her registration is endorsed for prescribing.

Chris flies out to remote health centre once a week to provide a physiotherapy service. Doctors periodically attend the centre, but none are present on the days that she visits the local communities. Here is a typical day for Chris.

9.00am: Chris sees Don, a farm worker, with a flare up of chronic low back and neuropathic leg pain. Don is happy to get his medicines from Chris because he knows she is subject to extensive training and robust standards, like his GP.

Following a thorough assessment and history-taking, Chris develops a treatment plan including behaviour modification, physical interventions and an analgesic review.

As an appropriate adjunct to existing physiotherapeutic management, Chris prescribes paracetamol and tramadol to bring Don's pain back under control while starting his physiotherapeutic interventions.

Don is booked in for a review appointment the following week to progress his exercises and to review his need for the pain killers. Chris hopes that she will be able to bring the pain killers down or even stop them if appropriate.

Don starts his course of medication straight after the consultation. As a result, he responds more quickly to his physiotherapy, leading to faster improvements in movement, performance and function.

Don is pleased because he has fewer physiotherapy sessions, taken less medicine to get well, hasn't had to make appointments with his GP or specialist, paid fewer gap payments, spent less on prescriptions and taken less time off work.

11.15am: Chris sees an elderly consumer, Margaret, who was recently discharged home from hospital after breaking her hip.

A few days before Margaret left hospital, she developed a chesty cough with green sputum. A sample was sent for testing on the day of discharge but Margaret refused to wait for the results as she was desperate to get back home.

The results showed Margaret has a chest infection that would respond well to the antibiotic amoxicillin.

Alongside progressing Margaret's hip and balance exercises, Chris teaches her effective airway clearance techniques and prescribes the antibiotics.

Now Margaret accesses appropriate medicines without unnecessary delay.

Chris gives Margaret advice about her medicines and alters one other medication to ensure the safe interaction of medicines. Chris explains how the physical and medical interventions will work together to get Margaret better as soon as possible.

Margaret is due to be reviewed by the nurse practitioner in three days so Chris gives a full hand over to the

nurse by telephone and in Margaret's medical notes so that her treatment plan has been communicated effectively.

2.30pm: Chris sees a Guugu-Yimidhirr woman, Liz, who has been having ongoing rehabilitation following a stroke seven months ago. Liz says that recently her pain has increased and she has found she has had problems with spasticity.

Chris is concerned that if not managed well, these factors will have a huge impact on physical ability and increase psychosocial drivers, and lead to another hospitalisation.

Following a review assessment, as the accountable prescriber, Chris discusses Liz's case with the extended multidisciplinary team by telephone. The team agrees with Chris that she should increase the patient's dose of baclofen, to help manage the spasticity, alongside physical interventions to optimise functional independence.

Chris also reviews Liz's pain killers to optimise her outcomes.

RECOMMENDATION

The APA recommends that the Physiotherapy Board of Australia apply to the Australian Health Workforce Ministerial Advisory Council for approval to endorse the registration of appropriately credentialled physiotherapists to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines related to their scope of practice.

ENDNOTES

[1] Australian Government 2015. *Budget paper no. 2: budget measures -part 2: expense measures – health,* viewed 16 February 2015, http://www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm

[2] The Coalition 2013. *The coalition's policy for Indigenous affairs*, viewed 16 February 2015, http://www.liberal.org.au/our-policies

[3] Australian Government 2015. *Budget paper no. 2: budget measures - part 2: expense measures – health,* viewed 16 February 2015, http://www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm

[4] Department of Health. 2015 *Primary health networks (PHNs),* viewed 22 April 2015, http://www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

[5] S14 Approval of endorsement in relation to scheduled medicines

(1) The Ministerial Council may, on the recommendation of a National Board, decide that the Board may endorse the registration of health practitioners practising the profession for which the Board is established as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines.

(2) An approval under subsection (1) is to specify—

(a) the class of health practitioners registered by the Board to which the approval relates; and

(b) whether the National Board may endorse the registration of the class of health practitioners as being qualified in relation to a particular scheduled medicine or a class of scheduled medicines; and

(c) whether the National Board may endorse the registration of the class of health practitioners in relation to administering, obtaining, possessing, prescribing, selling, supplying or using the scheduled medicine or class of scheduled medicines.

[6] S.94 Endorsement for scheduled medicines

(1) A National Board may, in accordance with an approval given by the Ministerial Council under section 14, endorse the registration of a registered health practitioner registered by the Board as being qualified to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicines if the practitioner—

(a) holds either of the following qualifications relevant to the endorsement—

(i) an approved qualification;

(ii) another qualification that, in the Board's opinion, is substantially equivalent to, or based on similar competencies to, an approved qualification; and

(b) complies with any approved registration standard relevant to the endorsement.

(2) An endorsement under subsection (1) must state—

(a) the scheduled medicine or class of scheduled medicines to which the endorsement relates; and

(b) whether the registered health practitioner is qualified to administer, obtain, possess, prescribe, sell, supply or use the scheduled medicine or class of scheduled medicines; and

(c) if the endorsement is for a limited period, the date the endorsement expires.

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