Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Wednesday 6th June 2019

Committee Secretary
State Development, Natural Resources and Agricultural Industry Development Committee
Parliament House
George Street
Brisbane Qld 4000

Re: Submission for Draft Medicines and Poisons (Medicines) Regulation 2019

Thank you for the opportunity to provide a submission on the Draft Medicines and Poisons (Medicines) Regulation 2019 introduced to the Queensland Parliament by the Queensland Minister for Health and Ambulance Services. The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation.

The APA congratulates the Queensland Department of Health on progressing this key area of legislation and in developing a draft bill that seeks to be representative of contemporary practice. The APA welcomes the carried forward amendments from the HDPR to the Medicines and Poisons Regulation 2019, to extend the authority of physiotherapists to administer a greater range of medicines that support effective and efficient physiotherapy assessment and management.

It is the APA's continued aim to deliver uninterrupted comprehensive patient centred care. This includes autonomous prescribing by all appropriately trained non-medical practitioners within their scope of their practice. We support continuity of service provision and coordinated care across programs, practitioners, organisations and levels. We believe that updating existing regulatory frameworks to reflect these goals can begin to address prevailing barriers, and we commend the Queensland government on their progressive stance.

Aligning with the APA's strategic objectives, we believe that healthcare services must focus on improving the consumer experience and must be safe and more effective than the current service model, at an equivalent or lower cost. The APA also believes that endorsing the registration of appropriately qualified health professionals to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine within their scope of practice will deliver modern, consumer-centred, high value healthcare.

Supporting our first recommendation is the professional competence of physiotherapists, acquired through their education and demonstrated commitment to subsequent professional development. It is also our position that professional practice needs to be constrained to that which is supported by appropriate setting-based safeguards. Because of this, we believe there is a compelling case for physiotherapists in Queensland to be provided with the authority to administer, to the extent necessary for them to practice physiotherapy, the relevant medicines that an authorised prescriber has prescribed, within their scope of practice. Underpinning this is the relevant training that is undertaken at an undergraduate level, the

competence demonstrated by entry level practitioners to safely administer medicines, and that the appropriate safeguards that are already in place to ensure the safety of the public is not comprised. This means that we have an opportunity to improve quality and access.

Informing our second recommendation is The Health Practitioner Regulation National Law Act 2009 (the National Law), which 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. A physiotherapist prescribing pathway endorsement will see timely access to medicines for consumers as part of an integrated and multidisciplinary model of care and will support the goals of the National Medicines Policy.

The work to progress an Australian model to facilitate this is well underway. It is likely this will occur in the lifetime of this piece of legislation, particularly as the precedent for prescribing of scheduled medicine by physiotherapists in the musculoskeletal setting has been set in Queensland, and has been shown to be an effective model to ensure continuity of care.

The APA believes it would be timely for the Medicines and Poisons Regulations 2019 to reflect the shift in contemporary practice. The extent of the authorisation to prescribe (including administer) is determined by reference to the endorsement under the National Law.
We believe a precedence has been set for national consistency in Section 86 of the *Medicines, Poisons and Therapeutic Goods Act 2015* in the Northern Territory, and provides that: a *"health practitioner may, in the course of practising in the health practitioner's health profession, issue a prescription for the supply of the regulated substance in accordance with the endorsed qualification*."

We suggest the committee consider the significant progress of non-medical prescribing health professions and adopt a similar nationally consistent approach. We believe an acknowledgement within this legislation to recognise new prescribers more broadly will facilitate the prompt adoption of prescribing, and support implementation when Ministerial approval is provided for a new endorsement.

We do acknowledge that the process to obtaining an endorsement to prescribe under the National Law is a lengthy one, and there is a risk that it will not be finalised before the termination of the QLD trial (title). As this will result in a loss of access to current services for patients presenting at emergency departments in Queensland, we would like to suggest, as an interim measure, an endorsement under the Extended Practice Authority for extended practice Emergency Department Physiotherapists who have undertaken the endorsed training program. We believe that safety and quality have already been demonstrated in this setting and the evidence is provided in our submission.

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We make the following recommendations for consideration to the new Medicines and Poisons Regulation 2019 (Appendix 1):

1. Allow administration for all scheduled medicines within scope of practice
2. Support the legislation to be able to adopt a nationally consistent framework for all non-medical prescribers' endorsements by recognition of new non-medical prescribers and ensuring the legislation does not restrict implementation.
3. Enable emergency department physiotherapists who have completed an endorsed training program to be granted an Extended Practice Authority under the relevant section of the Draft Medicines and Poisons (Medicines) Regulation 2019.

It is critical that modern legislation reflects imminent predicted changes that will be required to keep up with the rapid developments that are occurring in health care. This is particularly pertinent as we shift to a model that places a greater importance on high quality, patient centred care, embedded into a sustainable health system. This ensures we reduce the need for ongoing amendments and that unnecessary red tape does not restrict innovations in our health system.

We welcome the opportunity to discuss these recommendations further.

Yours sincerely,

Dr Ben Weekes
Queensland Branch President
Australian Physiotherapy Association
2728 Logan Rd
Eight Miles Plain
Phone: [redacted]
Email: [redacted]

Appendix 1 - Supporting Detail

Recommendation 1: Allow administration of Schedule 2, 3, 4 and 8 medication within the scope of practice of a physiotherapist.

The APA has concerns that the proposed amendments to the Medicines and Poisons Regulations is limited to specific conditions. The APA believes that by doing this it will have the effect of unnecessarily restricting access. It is suggested that physiotherapists have the authority to administer any relevant medicine, as prescribed by an authorised prescriber, to the extent necessary to practice physiotherapy. This could include Schedule 3, 4 or 8.

We believe there are medicines that are outside of the scope of the proposed changes, and which are integral to the practice of physiotherapy – that need to be administered to a patient in order to allow physiotherapy assessment and management to be optimised. For example, in cases of severe pain limiting movement and participation in physiotherapy, the administration of moderate to strong analgesia, including Schedule 4 and Schedule 8 medicines, could occur safely and optimise treatment[1].

There is evidence that such administration is safe and effective if undertaken in environments where there is sound clinical governance and where the physiotherapists act within their scope of practice[2]. While the administration of the medicines can, alternatively, be done by another authorised health professional, this has the undesirable impact of increasing time to optimal care and wastes both patient and professional resources.

The APA has noted in previous consultation papers in relation to the QLD drugs and poisons scheduling, that physiotherapists working in Queensland have the necessary entry-level education and training to administer medicines in a safe manner - the authority for physiotherapists to administer schedule 2 medicines has been available for some time and has been shown to be both safe and effective.

The examples below highlight the case for broadening the application of the administration inclusions for physiotherapy within the new Medicines and Poisons (Medicines) Regulation 2019.
Some medicines that are required to be administered to a patient by a physiotherapist, in an appropriate setting under clear clinical governance guidelines, having been prescribed by an authorised prescriber, to enable effective physiotherapy assessment and management to be undertaken include:

1. Schedule 4 analgesic medicines for moderate pain which is limiting movement and participation in physiotherapy assessment and management, which have been prescribed for the patient and may be required to facilitate the physiotherapy intervention. Particularly in cases where the patient has already taken schedule 2 medicines such as paracetamol and ibuprofen and have not reached the level of pain

relief required to allow them to participate. An unnecessary delay in providing adequate pain relief in a suboptimal outcome.

2. Schedule 4 muscle relaxants for severe muscle spasm limiting movement and participation in physiotherapy assessment and management.
3. Schedule 3 or Schedule 4 antiemetic for severe nausea and vomiting as an adverse reaction to opioid analgesia, to enable the patient to both participate in physiotherapy while the desired analgesic effect is in place and reduce the period of suffering for the patient.
4. Unscheduled and scheduled respiratory prescribed medications for respiratory disease to facilitate physiotherapy assessment or management including mucolytic agents and inhaled antibiotics
5. Nitrates or other symptomatic anti-angina treatments for symptomatic relief in cardiac disease while undertaking cardiac rehabilitation program or other exercise

We suggest the wording *Schedule 12 – Part 5 Physiotherapists* be amended to remove the words “pain relief’ or “respiratory condition” but includes the words “ to the extent necessary for physiotherapy assessment and management”. This will reduce the existing barriers to care while still ensuring that practice occurs only safely within the practitioners scope.

Physiotherapists in Queensland already have the necessary entry-level education and training to administer medicines within their scope of practice in a safe manner, and the authority to administer schedule 2 medicines has been in place for a significant period of time. Therefore, in order to provide the appropriate legislative framework to deliver safe and effective care to the public, physiotherapists in Queensland should be provided with the authority to administer, to the extent necessary for them to practice physiotherapy, the relevant medicines that an authorised prescriber has prescribed.

Recommendation 2 - Provide a nationally consistent framework medicines scheduling that supports the introduction of endorsed non-medical prescribers to practice within their scope without being constrained by state-based legislative barriers

There is considerable evidence that non-medical prescribing has not only a very strong safety record but also provides significant advantages to patients and the health system as a whole.[34]

Australia’s public healthcare system provides one of the highest levels of health in the world. To keep up with our changing circumstances. We must create an integrated health system which is accessible, affordable and sustainable, and can respond to a range of costs, changes in the population and patterns of illness, and our expectations about service delivery.
Healthcare providers are challenged to efficiently deliver equitable care to all Australians, particularly to people in rural and remote regions, and to older people, and the vulnerable and disadvantaged, who rely more on publicly funded healthcare. Current practice does not enhance patient centred care or health outcomes and it is not the most cost-effective use of available resources. In many circumstances, funding streams, red tape, legislative barriers

and workplace practice create a fragmented health system and add cost, complexity and duplication to the patient journey, and delay the patient's recovery, particularly the case in rural and remote Australia and in the public healthcare sector.

We need to enable quality improvement, innovation and greater productivity in service delivery. The National Health and Hospital Reform Commission (NHHRC) report recommends that roles of health professionals be extended, where appropriate, and utilised to address particular service gaps to help with the ever growing health care demands in Australia.[5]

Australia urgently needs to reform healthcare to ensure it is accessible, affordable and sustainable, particularly for people in rural and remote regions for Aboriginal and Torres Strait Islanders, for older people, and for the vulnerable and disadvantaged. These members of our communities often have poorer health and rely more on publicly funded healthcare. Under the current system, physiotherapists in Australia are only able to add a proportion of the increased value to improved healthcare of which they are capable. Extending prescribing responsibilities to physiotherapists, however, will create safe, innovative ways of working that improve the quality of services and the patient experience. It will help form partnerships across traditional professional and organisational boundaries and will build better care that is more cost-effective and sustainable, for example by improving the transition from acute to community care. It will ensure patients receive the right treatment at the right place and at the right time.

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. The APA believes that endorsing the registration of appropriately credentialed health professionals to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of scheduled medicine within their scope of practice will deliver modern, consumer-centred and better value healthcare. The work to progress an Australian model to facilitate this is well underway and it is likely that this will occur in the lifetime of this piece of legislation, particularly as the prescribing of scheduled medicine by physiotherapists in the musculoskeletal setting will be an effective and ensure continuity of care for patients

Musculoskeletal Disorders are those resulting in injury to the soft tissue, joints and bones, and are the cornerstone of physiotherapy practice. They can emanate from acute injury, orthopaedic, rheumatology, chronic postural and repetitive strain injuries in primary, outpatients and Emergency Department (ED) settings, are considered leading health issues and are an area of health priority. In 2014–15, based on self-reported data from the National Health Survey, more than 11 million Australians (50%) had at least one of eight selected chronic conditions (arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes mellitus, or a mental or behavioural condition) (ABS 2015e), Of these people, 5.3 million had two or more of the eight conditions" [6]

Enhancing access and improving quality of care for people with these conditions will have a significant impact on the burden of disease and reduce cost to the systems. Engaging physiotherapist to their full scope through endorsement to prescribe will address delays in

access to care and support the National Medicines Policy. Approximately 10% of all ED presentations are appropriate to be seen by a Primary Contact Physiotherapist (PCP). It was determined that the third most common reason for delays in managing PCP-appropriate patients, their patients in ED was due to delays in gaining access to prescribing analgesia. Considering that the main of the reason for delays in ED is timely access to medicines, one could imagine the impact that physiotherapists' access to prescribing and managing medicines can have on patients and the healthcare system.

It is important to acknowledge that the public safeguards that are required are already in place to support the safe application of these amendments. These relate to the requirements that will be set by the national framework and will apply to all non-medical prescribers in terms of demonstration of competency, practicing within guidelines and operating under governance frameworks.

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 the Board's Codes of Conduct, workplace rules and guidelines, and members of the APA are also subject to the rules and codes of membership. Physiotherapists are also subject to the criminal and civil legal system.

The Health Professionals Prescribing Pathway (HPPP) published by Health Workforce Australia (HWA) in November 2013 has developed a nationally recognised approach to the prescribing of medicines by health professionals (other than medical practitioners) registered under the National Registration and Accreditation Scheme[7]. When the framework for a nationally consistent framework for non-medical prescribing has been endorsed by the Australian Health Ministers Advisory Council it will describe the competencies required. Any practitioner applying for an endorsement will need to successfully complete a course of study approved by the Physiotherapy Board of Australia (or their relevant board), and only then apply for endorsement on their registration for prescribing. Only endorsed physiotherapists who have met these rigorous educational and practical experience requirements at a postgraduate level will be able to autonomously prescribe within their scope of practice.

The Prescribing Competencies Framework developed by NPS MedicineWise[8] contributes to achieving the QUM objective of the National Medicines Policy[9] by describing the competencies required to prescribe medicines judiciously, appropriately, safely and effectively. It provides a tool for all health professionals who have a right to prescribe medicines, regardless of their profession, to "help maintain safe and effective standards of prescribing"[10]

As has been articulated by the Queensland Directors of Allied Health Professions Office of Queensland that professionals who undertake to prescribe medicines will work within a multidisciplinary healthcare team and practice a collaborative approach to patient care. It is important to emphasise that prescribing by allied health professionals will complement current assessment, diagnosis and treatment processes within the scope of each profession[11].

The well-defined individual scope of physiotherapy supports autonomous prescribing. Whilst the prescribing activity of the profession as a whole may appear broad and diverse, the individual activities of any one prescribing physiotherapist will be focused only within their chosen specialist area of practice. This is because purpose of individual physiotherapist prescribing is to support and enhance the delivery of tailored physiotherapy interventions to patients. Individual physiotherapists who develop specialist expertise tend to do so in one area of clinical practice only and are not at risk of prescribing outside of their scope (e.g. respiratory vs emergency department) as they are prohibited from doing so. This will enable a clear articulation of the boundaries both within and outside of the profession.

Prescribing practice is currently considered an advanced practice activity. It will be part of an advanced practitioner's individual scope of practice subject to appropriate education, training and competence in prescribing activities. The post-registration educational programme in prescribing ensures advanced practice physiotherapists are equipped with the principles of prescribing to enable them to be safe, effective and cost-effective prescribers. Physiotherapist prescribers must ensure that they are able to apply the prescribing principles to their own area of practice, bearing in mind that this is a requirement for continuing registration as a prescriber. Physiotherapist prescribers must only prescribe within their scope of practice and understand that if they change clinical areas they may require a period of training before they are competent to prescribe in a new area of practice.[12]

The extended scope Emergency Department (ED) physiotherapist is a good example to articulate how autonomous prescribing within scope of practice works for physiotherapist. The goal of Primary Contact Physiotherapist (PCP) with prescribing rights in ED are to improve patient's outcomes, decrease the length of stay and increase the accessibility to individuals presenting with musculoskeletal problems. An example case scenario for an ED presentation is the case of acute ankle sprain with severe pain. Having the scope to "Prescribe" including to administer Nitrous Oxide gas, would be an efficient and an effective help to the patient to control their pain and reduce the risk of pain sensitisation. Advanced practice ED physiotherapists prescribe and administer pain relief for assessment and management of acute musculoskeletal conditions generally triaged at Category 3, 4 or 5. These are non-complex cases, as complex cases have already been prioritised[13].

The prescribing physiotherapists operate within a long-established model of care within the emergency department where they autonomously manage a wide variety of lower category, non-complex (Category 3, 4 & 5) musculoskeletal injuries such as minor fractures, dislocations, sprains and strains. Although the physiotherapists autonomously manage patients, they operate within the collaborative environment of the emergency department with appropriate local clinical and professional governance structures in place. Shared and collaborative decision-making usually takes place between medical staff, primary contact physiotherapists and nurse practitioners. Emergency Departments primary contact physiotherapists are regarded as extended scope practitioners, having completed post-graduate qualifications and specialise in musculoskeletal assessment, diagnosis, and treatment, playing an important role in acute injury management[14].

Non-medical prescribers must comply, as they would in their non-prescribing role, with Practice Guidance, other local, national and/or professional guidance and with any statutory requirements applicable to your prescribing practice. Failure to do so may would jeopardise their registration and raise concerns in relation to fitness to practise; ensuring that prescribers practice clearly within their own defined scope of practice and clinical specialty. This means it will be effective because the care, and interventions are relevant to the patient's needs and are based on established standards, and will achieve the desired outcome, such as effective pain management, reduced inflammation and improved function.

Prescribers must understand which legal framework they are using to prescribe medicines and must understand which types of medicine they are permitted to prescribe within that framework. They also must ensure they have appropriate indemnity cover in place to cover all your work, including prescribing.[15] As they have demonstrated competence in their areas of clinical specialisation, and do not undertake other treatment modalities that fall outside of their scope, they already understand that they are professionally accountable for their own prescribing decisions, including actions and omissions and are wholly responsible for all aspects of the prescribing process.

They must prescribe according to the available evidence base, which involves the application of the best available evidence in conjunction with clinical decision-making based on an individual's circumstances when making prescribing decision. They must use national sources of evidence as primary source of evidence-based prescribing and must be able to demonstrate that when a national source of evidence is not available, then a locally agreed practice based evidence or protocols has been used – thereby holding them to account for all decisions.

Recommendation 3 – Enable emergency department physiotherapists who have completed an endorsed training program to be granted an Extended Practice Authority under the relevant section of the Draft Medicines and Poisons (Medicines) Regulation 2019.

The goal of PCP with prescribing rights in ED are to improve patient's outcomes, decrease the length of stay and increase the accessibility to individuals presenting with musculoskeletal problems.
But people living in Queensland are not able to access new developments in health care that demonstrate improved access to medicines due to legislative barriers. In Queensland, prescribing by allied health professionals not already authorised under the HDPR7 must be undertaken within a formal research framework. Approval to obtain, possess, administer, prescribe or supply medicines must be sought from the Office of the Chief Health Officer prior to commencement of any trial[16]. This results in prohibiting positive evidence based research outcomes to be translated into practice – which is working against the value of evidence-based health care

There is now evidence in the Australian context to support the safety of this role for advanced practice Emergency practitioners. Since May 2017, eight physiotherapists who have completed tertiary level post-graduate prescribing training, have commenced autonomous

prescribing in five emergency departments in Queensland public hospitals (Cairns Hospital, The Prince Charles Hospital, Royal Brisbane and Women's Hospital, Queen Elizabeth II Hospital and Gold Coast University Hospital). This has been achieved through approval granted by the Chief Executive, Queensland Health, under Section 18(1) of the Health (Drugs and Poisons) Regulation 1996. The approval has been granted under a research trial protocol approved at each participating Queensland Health facility.[17]

Not yet published data has shown to date that the trial has enrolled and recorded the prescribing outcomes of 1500 patients. Data analysis shows that no prescribing errors or reports of medication misadventure incidents have been reported across 1600 written medication orders. Survey data from over 1050 patients in the trial indicate very high levels of patient confidence (>97%). Recently published data from subset analysis demonstrated comparable or better compliance with national medication charting guidelines when compared to traditional prescribers[18].

The physiotherapists have undergone significant training in prescribing and quality use of medicines through a curriculum that is likely to align with developing national framework, and embeds core concepts such as opioid and currently prescribe from a defined formulary that has been endorsed by the Healthcare Approvals and Regulations Unit which includes a variety of medicines from classes S2-S8. Importantly, the formulary has embedded opioid harm minimisation strategies such as a restriction on written prescriptions to a maximum of 10 x 5mg tablets of Endone along with a consultation with a senior medical officer for all discharge opioid prescriptions. Moreover, current trial data shows that physiotherapists have prescribed discharge S8 prescriptions for only 3% of patients, demonstrating their ability to successfully apply non-pharmacological strategies to good effect.

There are high levels of support from the multidisciplinary team in all of the emergency departments where the trial is active, with support to continue based on the knowledge of the education and training undertaken by the physiotherapists, the confidence in prescribing decision making and the improvements in efficiency and access for patients and the services.

To ensure continuity of patient access and service efficiency we recommend that the new Medicines and Poisons Bill and Regulation for the Chief Executive to grant an Extended Practice Authority, to trained physiotherapists in the emergency to continue to prescribe outside of the current research framework – as we expect that this will be the first step in facilitating a nationally consistent framework for all professions.

Supporting International evidence

In the UK, qualified and endorsed physiotherapists may prescribe medicines to their patients. Non-medical prescribing in the UK is safe and acceptable to patients and other clinicians, and its benefits include faster access to medicines, time-savings and improved service efficiency.[19] 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[202122]

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. [23] [24] [25]

This saving was compounded by less use of GP time, less use of prescriptions and earlier presentations resulting in fewer contacts per episode of physiotherapy care.[26] This suggests that there is potential for large reductions in GP appointments for self-referred consumers.
We believe 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[27]

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