

# Physician Assistants in Queensland: Consultation Paper

June 2016

## **Physician Assistants in Queensland: Consultation Paper**

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## Consultation arrangements

The Department of Health recognises and values the contributions of stakeholders and seeks to engage in a process to review the impact of practice related legislation and regulation on PAs, as well as other issues that influence the ability of PAs to work to their full practice scope.

Stakeholders are invited to consider the information provided in this paper, and respond to an online survey at: [www.health.qld.gov.au/clinical-practice/engagement/default.asp](http://www.health.qld.gov.au/clinical-practice/engagement/default.asp).

The deadline for submissions is **9am Wednesday 22 June 2016**.

Further information about the consultation may be obtained by contacting the Workforce Strategy Branch on 07 3234 1453 or via email at [PA@health.qld.gov.au](mailto:PA@health.qld.gov.au).

# 1. Introduction

Queensland's population is ageing, and a growing number of Queenslanders are living with chronic disease. Well-targeted clinical interventions offer the prospect of improved health outcomes. Health costs continue to rise and we need to be smarter about how we deliver health care into the future. Managing workforce shortages and ensuring the appropriate distribution of the health workforce remains a key challenge.

The Physician Assistant (PA) role has been widely adopted internationally. A PA is a member of a multidisciplinary team working under the delegation of a supervising medical practitioner. The role has similar diagnostic and therapeutic reasoning to a medical practitioner and is educated to be generalist in nature. A PA extends the practice of the medical supervisor by undertaking routine activities, allowing the medical practitioner to attend to other clinical priorities and more complex tasks. The collaborative relationship between a PA and supervisor is a defining feature of this role.

The Queensland and South Australian Governments have previously explored the opportunities and benefits of the PA model through two public health care sector pilots between 2008 and 2010<sup>1</sup>. New Zealand has also undertaken PA pilots across two phases between 2013 and 2015<sup>2</sup>. In 2013, the role was further enabled in Queensland through the implementation of a PA Governance Framework, including a PA Clinical Governance Guideline<sup>3</sup>, and supporting tools and templates.

The PA role offers a safe and cost effective workforce option that has many benefits. The Health Workforce Australia report, *The potential role of Physician Assistants in the Australian context*<sup>4</sup> (HWA report), and the Grattan Institute article *Access all areas*<sup>5</sup> (Grattan Institute article) note the positive contribution the role can make to the Australian health care sector, particularly in the underserved regional, rural and Indigenous communities.

While there is interest in the PA role in other jurisdictions, Queensland is currently the only state in Australia to utilise the role. Although there are benefits to the role, there are also practice-limiting factors. In order for the role to reach its full potential to deliver cost-effective quality health care, the role will need to be supported by the Commonwealth funded Medicare and Pharmaceutical Benefits Scheme and through enabling Queensland legislation, clinical governance and employment arrangements.

## 1.1 Purpose

This consultation paper describes the PA role and the current legislative and regulatory provisions governing PA practice in Queensland. The issues outlined in this paper are complex and frequently interdependent.

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<sup>1</sup> Evaluation of Physician Assistants in SA Hospitals: Final Evaluation Report. Department of Health – South Australia. May 2010

Evaluation of the Queensland Physician's Assistant Pilot: Final Report. Urbis Pty Ltd. August 2010

<sup>2</sup> Phase II of the Physician Assistant Demonstrations Evaluation Report: Report for Health Workforce New Zealand. Synergia Ltd. April 2015

<sup>3</sup> Physician Assistant Clinical Governance Guideline. Queensland Department of Health. March 2016

<sup>4</sup> The potential role of Physician Assistants in the Australian context: Final Report. Health Workforce Australia. November 2011

<sup>5</sup> Access all areas: new solutions for GP shortages in rural Australia. Grattan Institute. September 2013

Stakeholders are invited to comment on the opportunities and challenges facing the PA profession and ways to address these challenges. The Department of Health will review all feedback and use this information to inform options for further work to support the broader utilisation of the role.

## 1.2 Overview of key issues

There are a number of challenges to expanding the PA role in practice identified in this consultation paper. These include:

1. education program accreditation
2. clinical governance
3. professional regulation
4. authorities to practice
5. access to Medicare and Pharmaceutical Benefits Scheme
6. relationship to other clinical professions

## 2. The Physician Assistant workforce

### 2.1 International

The PA role was established in the 1960's in the United States of America (USA) to address issues of rural and remote health access, and the disparity of care in underserved populations. PAs are involved in most areas of medical and surgical practice. As of May 2015, there were 98,470 PAs licensed to practice in the USA. The PA role also exists in other countries, including Canada, United Kingdom, The Netherlands, Germany and South Africa.

### 2.2 Australia

There are approximately 40 Australian-trained PAs, with a small number employed in the public health care sector and the remaining in the private health care sector. Not all PAs working in the private health care sector are employed in that role.

The PA role is designed to be adaptable and it has the potential to be used in a number of diverse clinical environments. The HWA report noted that the PA role could make a significant contribution in Australia, by:

- reducing hospital emergency department waiting times by treating low-acuity patients
- reducing elective surgery waiting times by enhancing productivity of surgeons
- supporting and extending the career span of the rural and remote medical workforce
- providing services in regional, rural and remote areas, including Indigenous communities
- increasing the productivity of medical practitioners by releasing them from routine tasks, and
- providing a safe and cost effective workforce option.

The Grattan Institute notes that while rural General Practitioner (GP) numbers are slowly increasing, it is not enough to meet demand. Utilising the GP-PA model in underserved locations could expand the primary care currently available without compromising quality or safety, and at an affordable cost. Increasing access to health care in these areas could reduce the number of expensive hospitalisations.

Of James Cook University PA students, 50 per cent reside in regional areas, and are likely to seek work in regional and rural areas. The Grattan Institute suggests the PA role provides a cost-effective model to treat the escalating chronic disease problem in Australia. In order for the PA workforce to provide an effective solution to the challenges faced in underserved areas, support from State and Commonwealth Governments is required.

## 2.3 Queensland

Queensland PAs are primarily employed in roles designed to increase access to chronic disease clinics, fast-track patients in emergency departments and support general practice and medical specialists in the private health care sector.

In North Queensland, the Townsville Hospital has established a new model of care in the emergency department. The PAs work under the delegation of medical consultants, transferring patients from the Queensland Ambulance Service, making clinical assessments, ordering diagnostic tests and treating lower acuity conditions. This new model increases efficiency in the treatment, referral and discharge process. The initial evaluation data indicates the PA model has led to improvements in waiting times, patient satisfaction and clinician consistency in a department where traditionally most medical practitioners are on rotation.

In mid-2015, the Cherbourg Hospital in Central Queensland established a chronic disease clinic led by the superintendent and managed by PAs, with anecdotal evidence indicating the position made a significant difference to health outcomes. The PAs were also on-call in the emergency department, undertaking hospital rounds and providing medical services to an aged care facility. However, due to funding arrangements and Commonwealth legislative constraints, the positions have now ceased and the chronic disease clinic is no longer available to the Aboriginal community.

Other Queensland Hospital and Health Services have expressed an interest in the PA role as an addition to their multi-disciplinary teams.

In the private health care sector, a PA working under the delegation of a General Practitioner (GP) is employed in a Central Queensland community, with chronic disease management being the key focus of activity. The PA undertakes medical history checks, clinical assessments, setting clinical targets and measurement strategies and identifying risk of complications for referral to the GP. However, the PA is unable to bill Medicare for services provided.

In other locations, PAs are working for orthopaedic surgeons. One PA assists the supervising orthopaedic surgeon in surgery and another manages the patient clinic, including conducting assessments, pre-surgery arrangements with other specialists and post-operative patient reviews.

## 3. Key Issues

While there are many opportunities for the role to contribute to improved health outcomes, there are practice limitations in both the public and private health care sectors, due to Commonwealth legislative and State regulatory arrangements. There are also governance and scope limitations, including the need for on-going professional development pathways, credentialing of practitioners, and accreditation for the PA education program.

## 3.1 Education

The Bachelor of Health Science (Physician Assistant) is currently the only PA education program available in Australia, offered by the James Cook University (JCU).

The JCU program strongly aligns with The University of Washington, MEDEX Physician Assistant Program, an accredited education program in the USA, and one of the longest standing programs of more than 180 in the country.

The University of Queensland (UQ) offered a PA program at the Masters level from 2009 to 2012, graduating two cohorts of students. Due to limited employment opportunities at that time, UQ ceased the Masters program.

### 3.1.1 Accreditation of Education Programs

Accreditation enables the quality of education programs to be assessed and evaluated, and provides for recognition of domestic qualifications, as well as a basis for the assessment of internationally obtained qualifications.

The JCU Bachelor of Health Science (Physician Assistant) program is not accredited by an appropriate Australian accreditation entity, such as the Australian Medical Council (AMC). JCU is currently exploring the requirements for accreditation of their education program.

The AMC is responsible for assessing and accrediting medical education, training and professional development programs, and education providers against accreditation standards. The AMC could provide accreditation standards for PA programs in Australia.

### 3.1.2 Continuing Professional Development (CPD)

There is no consistent approach to the requirements for CPD outside the Queensland public health care sector, or for the recording or endorsement of PA CPD. Currently PAs are accessing CPD from a range of sources, including the Australian College of Rural and Remote Medicine (ACRRM). In 2011, ACRRM published a position paper which welcomed PAs to participate in ACRRM accredited CPD courses.

The Australian Society of Physician Assistants (ASPA) is developing a CPD Standard, and CPD points will be calculated accordingly. ASPA is a voluntary and self-registered professional body and currently there is no mandatory requirement to provide evidence of CPD.

#### Questions

- What is the most appropriate mechanism for the accreditation of PA education programs?
- How should PA CPD across all health care sectors be determined and recognised?
- How should overseas-trained PA qualifications be assessed?

## 3.2 Clinical governance

### 3.2.1 Public Health Care Sector

In the Queensland public health care sector, a PA Clinical Governance Framework (the Framework) has been established. The Framework provides the recommended minimum standards and processes for all clinically related aspects of the PA role, including supervision, delegation, practice exclusions, access to diagnostic tools and drugs and



poisons, and clinical audits. The Framework is underpinned by the application of a quality pre-practice verification and assessment process. The Framework can be viewed at [www.health.qld.gov.au/qhpolicy/html/index-p.asp](http://www.health.qld.gov.au/qhpolicy/html/index-p.asp)

The PA and the supervising medical practitioner define the medical scope of a PA in a practice plan. The practice plan is endorsed by the medical credentialing committee and reviewed when required or every three years. This endorsement process strongly aligns to other well-established clinical governance frameworks in the Queensland public health care sector.

### 3.2.2 Private and Not-For-Profit Health Care Sector

Private hospitals and facilities must meet standards outlined in the Private Health Facilities (Standards) Notice 2000, which require that a credentialing and clinical privileging committee be established. Credentialing of medical practitioners for practice in private hospitals is a similar process to that of the public health care sector.

At this time, there are no clinical governance requirements for a PA working in private practice to have their practice scope defined in a practice plan, or to undertake a credentialing process, or for the endorsement of their practice scope. Governance is currently dependent upon the employing agency/ individual to ensure the employed PA has obtained the appropriate qualifications, adheres to safe practice standards and is practicing within the scope of practice of the supervising medical practitioner.

#### Questions

- Are the clinical governance mechanisms in place to support PAs in the public health care sector appropriate?
- What clinical governance mechanisms should be in place to support PA practice in the private and not for profit health care sectors?

## 3.3 Professional regulation

Clear definition of the PA role will provide a level of protection for health consumers and the wider community by ensuring the individuals practicing as PAs have the necessary education, qualifications, and experience to provide the health care services required of the profession.

Clinical professions are recognised and defined in a range of ways. Nationally registered practitioners have title protection. However, without national registration through a national board under the Australian Regulation Health Practitioner Agency (AHPRA) there are other ways to define a PA.

PAs are currently practicing as a self-regulated profession. ASPA is the national peak body for PAs in Australia. In addition, the Rural Doctors Association of Australia (RDAA) and Australian College of Rural and Remote Medicine (ACRRM) has extended associate membership eligibility to PAs. Membership of ASPA, RDAA and ACRRM is voluntary.

The *National Code of Conduct for Health Care Workers (Queensland)* further strengthens regulation of the PA profession. The Health Ombudsman in Queensland has powers to take action in relation to unregistered health service providers, including taking immediate action and the issuing of interim prohibition orders.

As the PA is a delegated role, a robust clinical governance framework may be sufficient to ensure appropriate regulation. Increasing regulation would need to be commensurate to the potential risk this profession poses, regulatory burden and cost benefit analysis.

#### Questions

- What arrangements should be in place to ensure that PAs are appropriately and clearly defined?
- What additional regulatory measures should be in place to provide public protection and ensure quality and safe service delivery by PAs?

## 3.4 Authorities to practice

### 3.4.1 Medicines

The *Health (Drugs and Poisons) Regulation 1996* (Queensland) (HDPR) identifies the medicines handling authorities of PAs in Queensland.

PAs employed in the public health care sector are authorised to possess, administer, prescribe, or supply Schedule 2, 3, 4, and 8 medicines and to give someone who may administer or supply the schedule medicines oral or written instructions to do so, as defined in the endorsed PA practice plan.

In contrast, PAs working in the private or not-for-profit health care sectors are not authorised for medicines handling activities of any kind.

In the private health care sector, the supervising medical officer is required to complete all medicines prescription forms, and perform all medicines handling activities or delegate them to other health professionals with the appropriate authorities. This significantly limits the PAs ability to undertake key activities expected of their role, and reduces their capacity to support the supervising medical officer.

Amending the definition within the HDPR to incorporate all PAs may provide a partial solution. However, consideration of the safety and appropriate medicines handling practices, credentialing and governance procedures, within the private and not-for-profit health care sectors is required.

Commonwealth legislation further limits the prescribing of medications by PAs in all sectors. PAs are not eligible for a Prescriber Number or able to access benefits under the Commonwealth Government Pharmaceutical Benefits Scheme (PBS).

### 3.4.2 Diagnostic procedures

The *Radiation Safety Regulation 2010* (Queensland) (RSR) lists the authorities for PAs to order medical imaging in Queensland.

PAs employed in the public health care sector are authorised to request a diagnostic procedure, as defined in the PA practice plan. However, PAs working in the private or not-for-profit health care sectors are not authorised to order diagnostic tests. This further limits their ability to work to full practice scope, and provide adequate support to the supervising medical officer.

Prior to potential amendments of the RSR, further work will be required to identify the governance processes outside of the public health care sector that would support the inclusion of all PAs.

Commonwealth legislation further limits the ordering of diagnostic tests by PAs in all sectors, as they are not eligible for a Medicare Provider Number to request diagnostic services by private providers.

#### **Questions**

- Should PAs working across all health care sectors be provided the same authorities under the HDPR for medicines handling, and under the RSR for the requesting of diagnostic procedures?
- If you do not agree, what would be appropriate?
- What are the significant barriers to enabling these authorities?

## **3.5 Access to Medicare and Pharmaceutical Benefits**

### **3.5.1 Funding Models**

The way in which the public health care sector is funded can affect the costs associated with PA delivered health services. Within Queensland Health, PAs working under delegation in a public facility funded under Activity Based Funding (ABF) arrangements do not require a Medicare Provider Number to perform activities.

However, a Hospital and Health Service providing services under Block Funding arrangements must meet any costs incurred from services provided by a PA, including services provided to patients with private medical insurance. This typically affects rural and remote health services.

Own Source Revenue (OSR) activity is a key source of Hospital and Health Service funding, particularly for facilities located in rural and remote regions. OSR is revenue generated from general patient treatment provided over pre-set target levels, as well as services provided to non-public patients<sup>6</sup>. Only clinicians with a Medicare Provider Number can attract a Medicare Benefit Scheme benefit for services provided to eligible patients under these circumstances. Currently, PAs are not eligible for a Medicare Provider Number.

Within the private health care sector, the employing facility and/ or medical practitioner meets the costs of PA provided services.

### **3.5.2 Commonwealth Legislative Restrictions**

#### **3.5.2.1 Access to the Medicare Benefits Scheme (MBS)**

Some medical practitioners and PAs have identified lack of access to the MBS as the most pressing issue affecting the uptake of the role.

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<sup>6</sup> Such as Department of Veterans Affairs, workers' compensation, personal injury insurance, and Medicare ineligible patients

In order for a professional medical service to attract a Medicare benefit, the clinician is required to have a Medicare Provider Number (MPN). However, the Commonwealth Government does not recognise PAs as health professionals eligible to apply for a MPN.

Within the public health care sector, and outside of the urban and regional ABF funded public health facilities, a clinician requires a MPN in order for their services to attract a Medicare benefit. If a PA provides services in these areas, the facility will be required to bill the patient the full cost of service, or absorb the cost of providing the service.

In addition, without a MPN, PA requested diagnostic tests do not attract an MBS benefit, costing the patient the full service fee. In order for MBS benefits to be paid to the patient, the PA must have all diagnostic test requests completed by their supervising medical officer.

Access to a range of MBS item numbers would significantly improve the ability of PAs to deliver required health services. Not having access to the MBS is not only limiting the practice of PAs in the public and private health care sectors, it increases the costs of service delivery for the employing Queensland hospitals and health facilities. Not having a MPN also prevents the PA from authorising services that attract a Commonwealth Government benefit, such as Chronic Disease Management Plans.

### **3.5.2.2 Section 19(2) Restrictions and Exemptions**

Section 19(2) of the *Health Insurance Act 1973* (Commonwealth) determines that MBS benefits are not payable for any service that is provided where and when other government funding is provided for that service. Exemptions to S19(2) allow certain professions at specifically exempted sites to provide various non-referred professional services that attract a Medicare benefit, when provided in out-patient clinics and emergency departments<sup>7</sup>.

These 'S19(2) exemption' services are typically provided where there are a limited number of GPs in relation to the population, and primarily this will be in remote and/or Indigenous communities. PAs are not authorised to claim against Medicare for services provided under the S19(2) exemption.

PAs in Australia were proposed as a profession that could contribute to access to medical care in rural and remote areas and are recognised as making a positive contribution to these communities. The lack of access to the MBS significantly affects their ability to deliver services and the financial viability of the role.

The issues of accessing funding and access to Commonwealth benefit programs are not limited to the PA profession. Nurse Practitioner, Midwife and Allied Health professions experience similar barriers to deliver services in rural and remote areas.

### **3.5.2.3 Access to the Pharmaceutical Benefits Scheme (PBS)**

Medications listed on the PBS only attract the PBS subsidy if prescribed by a clinician who holds a PBS prescriber number. PAs are not recognised as an eligible health professional under the PBS, and therefore, medicines prescribed will not be eligible for PBS subsidy. Patients would be required to pay the full cost of supplying the medication.

Not having access to the PBS restricts the practice of PAs, and it can increase the costs of service delivery for some Queensland hospitals and health facilities.

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<sup>7</sup> Including midwifery, nursing, allied and dental services

In the public health care sector, PAs are excluded from prescribing PBS eligible medications. Therefore, the supervising medical officer must review the patient, write and sign the prescription. This is inefficient and may not be feasible where the PA is working under indirect or remote supervision.

The inability of PAs to prescribe PBS medications and attract a PBS benefit has been identified as reducing the efficiency of the PAs and preventing them from working to their full practice scope. In the USA, PAs have the authority to prescribe controlled medications under the delegation of their supervising medical officers. This capacity allows for more effective practice by the Physician-PA team.

### Questions

- Should PAs be recognised as a PBS prescriber?
- Should PAs be recognised as a professional eligible to provide medical services which will attract Medicare benefits?
- If yes, should PAs have access to:
  - A) The Medicare item numbers required for the individual PA practice type and location?  
or
  - B) Item numbers that align with their supervisor's Medicare item numbers?  
or
  - C) A broad group of MBS item numbers that apply to all PAs regardless of location and practice type?

## 3.6 Relationship to other clinical professions

Prior to, and during the Australian PA pilots, concerns were raised about the potentially negative impact the role might have on other clinical professions. In particular, it was considered that PAs and PA students would compete with medical students for clinical education placements.

Subsequent to the Queensland pilot, the Australian Medical Student Association (AMSA) published a policy paper on PAs in which AMSA stated that the PA's would be competing for vocational training and professional supervision<sup>8</sup>.

To date there is no evidence suggesting clinical placement conflicts exist between medical students and PAs. JCU has advised that PA student clinical placements are carried out with maximum sensitivity to medical student training across the country. Clinical placement is coordinated through the College of Medicine to ensure conflicts do not arise. PA students often access clinical placement during times when medical students are on semester breaks or summer holidays.

Anecdotal evidence has shown that in some situations the experienced PA has enhanced junior doctor training, and allowed the supervising medical practitioner more time to provide training to junior doctors and vocational trainees, which has supported and enhanced training opportunities<sup>9</sup>.

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<sup>8</sup> Physician Assistant's Policy. Australian Medical Students Association. Adopted 2010, reviewed 2015.

<sup>9</sup> Also evidenced in the USA

Clinical rotations for medical registrars are a requirement of medical training and are critical to enable clinical exposure to increase competence and experience. An expansion of the PA role would require consideration of a coordinated and balanced approach to the employment of PAs, ensuring optimal levels of registrar opportunities are maintained.

In Queensland, NPs and PAs currently work together in multidisciplinary teams, which is a common feature of the two professions internationally. Due to some practice activity commonalities between the PA and Nurse Practitioners (NP) and other advanced nursing roles, there is interest in the relationship between the two roles.

PAs are different to NPs. NPs are the most senior clinical nurses, and are endorsed independent practitioners that function autonomously and collaboratively in a clinical specialty. PAs are not independent practitioners. While PAs practise medicine and have similar diagnostic reasoning to medical practitioners, they undertake activities determined by their supervisor.

A variety of workforce options are available in Queensland and, depending on the local requirements, it is recommended a skills mix assessment be undertaken to ensure the most appropriate available clinicians are employed to meet the local service needs.

**Question:**

- How do you see the PA role influencing or affecting other clinical professions?

## 4. Conclusion

The numbers of PAs working in Queensland is very small in comparison to other clinical professions. However, Australian and international evidence supports the role as a safe and sustainable workforce option for Queensland, particularly in those areas that would benefit from alternate methods of health care service delivery.

The issues described in this paper were identified by PAs, PA employers and supervisors, and other clinical professions, as currently having a major impact on the sustainability of the role in Queensland. Your consideration and input is appreciated.



## **Physician Assistant Practice in Queensland: Consultation Paper**

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