RACGP
Royal Australian College of General Practitioners

Healthy Profession. Healthy Australia.

29 January 2026

Apolline Kohen
Committee Secretary
Department of the Senate
via email: community.affairs.sen@aph.gov.au; seniorclerk.committees.sen@aph.gov.au

Dear Apolline Kohen,

Thank you for the opportunity to review the *Health Legislation Amendment (Prescribing of Pharmaceutical Benefits) Bill 2025* which amends the *National Health Act 1953* (NH Act) and the *Health Insurance Act 1973* (HI Act) to:

- Establish a process by which eligible registered nurses who meet specified criteria may be approved by the Secretary as authorised nurse prescribers.
- Provide mechanisms for the Secretary to suspend or revoke such approvals.
- Include authorised nurse prescribers as a category of the Pharmaceutical Benefits Schedule (PBS) prescriber and enable the Minister to specify the pharmaceutical benefits they may prescribe.
- Ensure that patients receiving treatment from authorised nurse prescribers can be prescribed pharmaceutical benefits on the PBS.
- Make consequential amendments to reflect the inclusion of authorised nurse prescribers as a new PBS prescriber type.
- Enable the Professional Services Review (PSR) to review the PBS prescribing by authorised nurse prescribers. (HI Act) This will ensure authorised nurse prescribers are subject to the same oversight as other PBS prescribers.

The Royal Australian College of General Practitioners (RACGP) is the voice of specialist general practitioners (GPs) representing more than 50,000 members in our growing cities and throughout rural and remote Australia. For more than 60 years, we've supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians.

Our core commitment is to support GPs from across the entirety of general practice to address the primary healthcare needs of the Australian population. The College trains more than 90% of Australia's GPs including those in rural and remote areas and in Aboriginal and Torres Strait Islander communities.

The RACGP stands by its previous position on Designated Registered Nurse Prescribing (DRNP). We support DRNP within a limited range of conditions, under a specific prescribing agreement and only in a team-based environment (medically supported).

Skills and training

The RACGP continues to caution the ongoing conflation of diagnosing and prescribing skills. In recent years it appears to have become common practice for state and territory medicines and poisons legislation to "water down' legislative governance arrangements, informed by the Therapeutic Goods Administration's scheduling of medications processes which are designed to embed safety and quality after a rigorous examination of risk and complexity. **The RACGP recommends additional legislative guardrails be included in the draft legislation to prevent states and territories circumventing national, TGA informed restrictions and allowing open prescribing rights.**

We do not support DRNP prescribing of Schedule 8 medicines and recommend the legislation explicitly prohibit DRNP prescribing of these medications due to the increased complexity of these medicines, which require rigorous and comprehensive education with a robust, evidence-based scaffolding of medical science, and a period of structured clinical training and supervision. More broadly lack of DRNP access to Real Time Monitoring Programs is a concern due to the high potential for misuse of these drugs.

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Medical oversight

The RACGP has concerns about non-medical practitioners acting as the authorised health practitioner in DRNP prescribing agreements and recommends the legislation explicitly prohibit this arrangement. We also recommend the definition of an authorised health practitioner be clarified and included in the draft legislation. Prescribing agreements need to be carefully restricted to ensure patient safety and avoid the fragmentation of care. While the current guideline allows for medical practitioners and nurse practitioners (NPs), we understand consideration is being given to expanding this to include endorsed podiatrists, endorsed optometrists, endorsed midwives and prescribing pharmacists in the future. Prescribing should be limited to circumstances where there is a recognised access-to-care deficit, doctor-led prescribing cannot be accessed (even through appropriate telehealth services) and limited to medicines that can be safely prescribed within the health professional's skill set. Authorised prescribers must be free from commercial conflicts of interest.

While NPs are authorised health practitioners within prescribing agreement frameworks, it is acknowledged they do not possess the same breadth or depth of medical training as medical practitioners. Pharmacology training, diagnostic training, interpretation of tests, medication monitoring differs significantly from NPs to that of GPs. As such, the medicines that can be prescribed by NPs, need to be carefully selected to be safe and appropriate.

Regulatory oversight and alignment

We support enablement of the PSR to ensure the same oversight of DRNPs as per other kinds of PBS prescribers.

However, proceeding with PBS prescribing reforms in the absence of finalised NP accreditation standards, clear scope boundaries and equivalent professional safeguards risks undermining patient safety, role clarity and integrity of collaborative prescribing models.

The proposed reforms to NP accreditation standards have removed some of the existing safeguards (in addition to the abolition of collaborative arrangements). For example, admission criteria to NP training programs have been relaxed significantly to reduce the pre-requisite total hours of clinical and advanced nursing experience as a registered nurse. The long-standing requirement for NPs to practice within a defined field of practice has also been removed reflecting a shift toward a more generalist model.

Whilst some reforms have strengthened regulatory alignment with general practice - including the introduction of recency of practice for endorsement and the creation of a non-clinical NP category- substantial gaps remain between the training, clinical exposure and diagnostic breadth of GPs and NPs. Of particular concern is the proposal for NPs to be subject to only 30 Continuing Professional Development (CPD) hours annually. We do not support a lower CPD threshold for practitioners seeking to practise autonomously or deliver services that substantially overlap with a GP's scope of practice. **Where health professionals are authorised to provide autonomous care and duplicate elements of GP service delivery, they must be required to meet equivalent standards of training, assessment and ongoing professional development as GPs, which is a minimum of 50 CPD hours annually.**

Please contact Shayne Sutton – Chief Advocacy Officer, if you wish to further discuss anything in this correspondence.

Yours sincerely

Dr Michael Wright
RACGP President

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