Griffith UNIVERSITY

Centre for Applied Health Economics

BUDGET IMPACT ASSESSMENT OF PHARMACEUTICAL BENEFITS SCHEME SUBSIDIES FOR PATIENTS OF ENDORSED PODIATRISTS AND PODIATRIC SURGEONS V3.0

April 2020

A report by the Centre for Applied Health Economics (CAHE), Griffith University

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ACKNOWLEDGEMENTS:

The Project Team would like to acknowledge: The Australian Podiatry Association for their assistance with circulating the survey and reminders to respondents; the Allied Health Professions Office of Queensland for providing contact lists and reviewing draft versions of the report; Anthony Short for providing subject matter expertise with regard to private practise; all survey and report draft reviewers who provided comments; as well as all respondents who took the time to complete the survey questionnaire.

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EXECUTIVE SUMMARY

INTRODUCTION

Non-medical prescribing has been shown to improve access to medicines for communities, promote workforce flexibility, contribute to quality of care and provide a cost-effective alternative to medical prescribing. Despite their potential to improve health outcomes, provide service efficiency, and avert future clinical complications, podiatrists and podiatric surgeons are not listed under Section 88 of the National Health Act and, hence, are not eligible to provide their patients with prescriptions subsidised under the Pharmaceutical Benefits Scheme (PBS). This report determines the financial implications for the health budget if podiatrist scripts were reimbursed under the PBS.

METHODOLOGY

A survey was designed (based on requirements for a financial impact analysis [FIA]) in order to define podiatrist prescribing habits. This was considered the most appropriate approach as there is currently no systematic monitoring of podiatrist prescriptions. The survey included questions to capture information on respondent and patient characteristics as well as quantitative data on the number and type if scripts written. An invitation to complete the online survey via Qualtrics® was sent to podiatry education providers in Australia and to registered podiatrist and podiatry surgeons via email from the Australian Podiatric Association. The survey remained open from the 23rd November to 14th December 2020

Following the final data-cut, outliers and nonsensical values were removed from the dataset. Simple descriptive analyses were conducted using SPSS (Version 27) to define central tendency as well as spread for each variable.

Once the survey dataset was finalised, an FIA was conducted based on the market share approach set out by the Pharmaceutical Benefits Advisory Committee guidelines.

RESULTS

The total impact of podiatry prescribing on the health budget including offsets from patient co-payments and MBS-fees was expected to be $1,282,128 over a six-year period from 2021 to 2026.

DISCUSSION

Our analysis demonstrated a relatively low six-year financial impact to the Commonwealth Health Budget if prescriptions written by endorsed podiatrists and podiatric surgeons were subsidised under the PBS.

The inclusion of subsidies for podiatrist-prescribed medicines under the PBS may also be associated with several benefits. Some of the benefits identified during the survey include: The monitoring of scripts under the PBS would allow for inclusion of podiatrist-prescribed medicines into quality use of medicines initiatives (such as the Opioid Stewardship Programme and the Antimicrobial Stewardship Programme); The avoidance of script-redirection to medical prescribers, to receive PBS-subsidy, may reduce the likelihood of complications in time-sensitive conditions (such as diabetic foot ulcers); and the recognition of podiatrist-prescribed medicines under the PBS would bring the profession in-line with other non-medical prescribing professions, including optometrists, nurse practitioners, and dentists.

Further, the associated benefits in clinical outcomes may produce additional health budget and societal cost-savings which were not considered in the current analysis.

INTRODUCTION

An ageing population with increased co-morbidities and chronic diseases is placing an enormous burden on the Australian healthcare system (Australian Institute of Health and Welfare, 2018). With these greater demands, there is a need for government to adopt more effective, efficient and sustainable approaches to healthcare service delivery.

The extension of prescribing rights is an important issue in health workforce reform in Australia (Health Workforce Australia, 2013). Non-medical prescribing can result in improved access to medicines for communities, promote workforce flexibility, and contribute to safe and cost-effective care (Australian Physiotherapy Association, 2015; Bhanbhro S, 2011; C. I. Hale A, Stokes J, Aitken S, Clark F, Nissen L, 2015; M. J. Hale A, Coombes I, Mc Dougall D, Coombes J, Nissen, L, 2014; Hale AR, 2013; Morris & Grimmer, 2014; Weeks GJ, George J, Maclure K, & D, 2016).

The ability to prescribe better utilises the skills of podiatrists and podiatric surgeons to meet the increasing demands placed on the health care system (Borthwick, Short, Nancarrow, & Boyce, 2010). Podiatrists and podiatric surgeons with an endorsement for scheduled medicines have the potential to improve health outcomes, service efficiency, and avert future clinical complications (Couch, Foo, James, Maloney, & Williams, 2018).

Despite their important role in the treatment of podiatric conditions, podiatrists are not listed under Section 88 of the National Health Act and, hence, are not eligible to provide their patients with prescriptions subsidised under the Pharmaceutical Benefits Scheme (PBS). Podiatry and podiatric surgery are currently the only remaining professions that have a national endorsement for scheduled medicines and yet can't write PBS-subsidised scripts. This leaves endorsed podiatrists and podiatric surgeons to rely on alternative prescribers or write private prescriptions which are charged at full price to the patient.

The absence of PBS subsidy creates a number of unmet clinical needs. Two notable issues include hinderance of timely access to treatment and patient noncompliance. Currently, patients who are unable to pay for a private script will need to visit a PBS-eligible prescriber, such as a GP, or not fill their script. In the survey conducted as a part of this report, podiatrists approximated that on average 7.3% (95% CI: 4.4%, 10.3%) of their prescriptions are not filled. The resulting noncompliance is likely to impact patient outcomes. The alternative approach – redirecting patients to a PBS-endorsed prescriber – creates additional burden on health resources and delays access to treatment. This can substantially impact outcomes from conditions which are often time-sensitive. For example, outcomes following diabetic and high-risk foot complications have been found to be critically reliant on timely treatment to prevent severe infections and reduce the risk of lower extremity amputation (Lipsky et al., 2012).

This study aims to examine the financial implications for the Australian Government if prescriptions from endorsed podiatrists and podiatric surgeons were eligible for subsidy under the PBS. Information from this study will help to inform policy makers about the financial impacts of recognising endorsed podiatrists and podiatric surgeons as eligible prescribers for the PBS.

METHODOLOGY

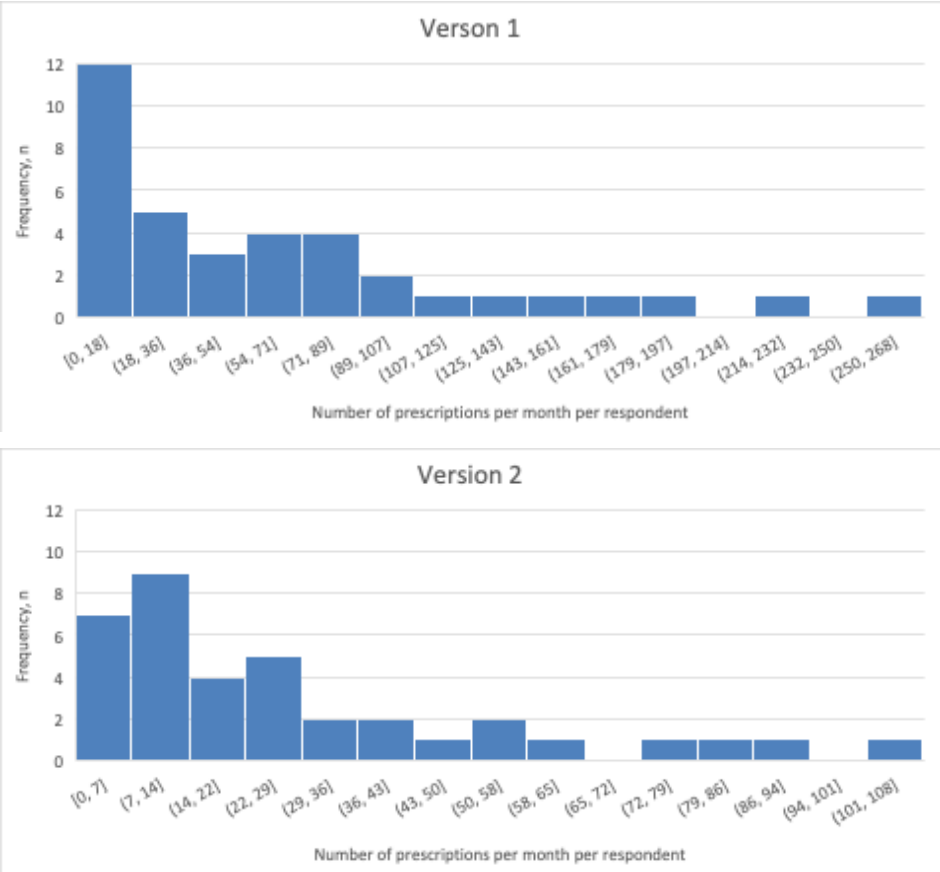
An online survey was developed in order to estimate key inputs for the podiatrist prescribing financial impact analysis (FIA). The survey questions were informed by the FIA guidelines set out by the Pharmaceutical Benefits Advisory Committee (PBAC) and associated data-gaps in publicly available information. Survey questions were then formulated based on the identified data-gaps (Appendix 1 Data cleaning and prescription uncertainty
Following the final data cut (14th December 2020), the data were cleaned and organised using SPSS (Version 27). This included:

- Variables were given appropriate names
- Labels were created for categorical variables (such as age categories and sex)
- Full entries with incomplete/inappropriate data were removed from the dataset
- Entries for individual variables which were considered nonsensical were removed from the dataset.

Once the data were organised, preliminary analyses were conducted on the data to explore central tendency and spread of responses. The dataset at this point (Version 1) indicated the average number of scripts/month/prescribing podiatrist was 64 – which was considered to be substantially higher than what would be expected in reality. Further, a histogram of the distribution of total scripts/month indicated a substantial skew and outliers to the right (**Error! Reference source not found.** – Version 1).

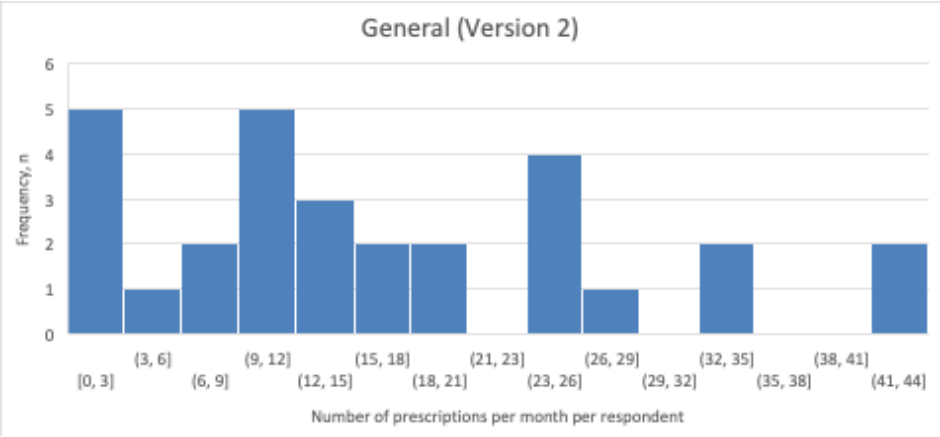
In order to handle outliers, a Z-distribution was produced for each medication. Responses which were more than +/- 2 z-scores from the mean were identified as outliers and removed from the analysis. A z-score of 2 was considered an appropriate outlier threshold to preserve responses in a small survey. This was done separately for general and surgical podiatrists as prescription numbers varied substantially between these groups. Following these changes, the dataset shifted to a more parametric shape, however, there was still a substantial skew to the right (**Error! Reference source not found.** – Version 2).

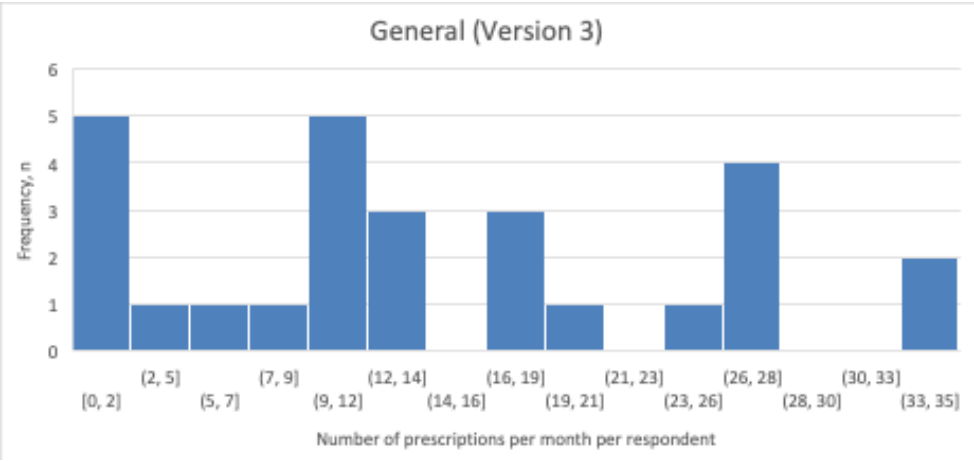
Figure 1: Distribution of survey responses by prescribing quantity per month



Following the identification of outliers in individual medication fields, the dataset was interrogated for outliers based on total respondent prescribing. Respondents who had a total prescribing number +/- 2 z-scores from the mean were removed from the analysis. This was done separately for general and surgical podiatrists as prescription numbers varied substantially between these groups. Only two respondents in the general podiatrist prescribers group fit these criteria. The change in distribution for general podiatrist prescriptions shifted towards the mean.

Figure 2: Distribution of general podiatrist prescription quantity per month





Overall, the final prescription distribution indicates there is still a skew towards the right. Following removal of outliers, the average prescription volume per prescribing podiatrist dropped from 64.3 (SD: 66.4) scripts per month to 29.7 (SD: 28.3) scripts per month. Based on focussed consultations with prescribing podiatrists, this figure was still considered to be high. It was considered that due to recall bias, respondents tended to overstate their prescribing volumes. Despite this, it was considered that a financial impact analysis constructed using overstated prescription numbers was still informative to Department of Health decision making.

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Attachment 1 Survey design). Survey questions were reviewed and agreed upon by the Griffith CAHE research team and members from the Allied Health Professions' Office of Queensland (AHPOQ).

The finalised survey (Attachment 2 Survey questions) captured information on respondent and patient characteristics as well as quantitative data on the number and type of podiatry scripts written. For quantitative data on scripts, endorsed respondents were asked to enter the average monthly number of scripts written for each medicine in the National podiatry schedule medicines list (Attachment 3 National Podiatry Scheduled Medicines List) (Podiatry Board of Australia, 2018)

Ethics approval for the survey was sought from Griffith University (GU) (Protocol number: 2020/795). The survey was anonymous with no identifying information provided to GU researchers. Completion of the survey was taken as implied consent.

An invitation to complete the survey online via Qualtrics® was emailed to podiatrists and podiatric surgeons based at Australian education institutions including the Queensland University of Technology, Central Queensland University, Southern Cross University, Charles Sturt University, Latrobe University, University of Western Australia, University of South Australia, Western Sydney University, and to College of Podiatry Deans. An invitation was also emailed to registered podiatrists and podiatric surgeons by the Australian Podiatric Association (Attachment 4 Survey letter). Recipients of the invitation were also asked to distribute the survey to podiatrists and podiatric surgeons within their network. The survey remained open from the 23rd November to 14th December 2020.

Following the final data-cut, outliers and nonsensical values were removed from the dataset. This process is discussed further in **Error! Reference source not found.**. Simple descriptive analyses were conducted using SPSS (Version 27) to define central tendency as well as spread for each variable.

Once the survey dataset was finalised, an FIA was conducted based on the market share approach set out by the Pharmaceutical Benefits Advisory Committee (Version 5; Pharmaceutical Benefits Advisory Committee, 2016). The number of endorsed podiatrist prescribers was projected from 2021 to 2026 based on historical trends (2016 to 2020; Australian Health Practitioner Regulation Agency annual reports). The total number of scripts was then calculated by combining the average prescribing volume for each medication – which was captured in the survey – with the projected number of podiatrist prescribers. The FIA excluded the proportion of scripts redirected to alternative prescribers to avoid double-counting in incremental PBS-subsidised scripts. In order to facilitate scenario analyses, the FIA worksheet also calculated changes in accreditation which may arise in different scenarios; such as increased interest in accreditation following PBS-subsidy or changes in accreditation courses.

The results of the podiatrist prescribing survey and FIA are presented to align with Section 4 of the PBAC submission guidelines (Version 5; Pharmaceutical Benefits Advisory Committee, 2016).

RESULTS

SURVEY RESPONDENTS AND APPLICABILITY TO AUSTRALIAN PODIATRISTS

Survey respondents demonstrated similar characteristics compared with registered podiatrists in Australia. In total, we received 164 responses over the survey period. Compared with registered podiatrists in Australia, the survey respondents demonstrated comparable age, sex, and location of practice (Table 1). This indicates that results observed in the survey are applicable to the Australian population of podiatrists.

The response rate for general podiatrists who are endorsed to prescribe, and surgeon podiatrists was higher compared with the Australian population of podiatrists. This was not considered to be an issue as average prescription rates from the survey were stratified and extrapolated over the Australian population of podiatrists by general and surgeon endorsements.

Table 1: Comparison between survey respondents and Podiatry Board of Australia registrant data

	Podiatrist survey results [1]			**PBA registrant data [2]**		
	N	**n**	**%**	**N**	**n**	**%**
Registration type amongst podiatrists						
General	155	147	94.84	5,470	5,434	99.34
Surgeon	155	8	5.16	5,470	36	0.66
Podiatrists who are endorsed to prescribe						
Total	155	35	22.58	5,470	144	2.63
Surgeon	155	8	5.16	5,470	36	0.66
General	155	27	17.42	5,470	108	1.97
Age group (years)						
u 25	162	11	6.79	5,613	336	5.99
25-34	162	51	31.48	5,613	2,239	39.89
35-44	162	52	32.10	5,613	1,361	24.25
45-54	162	29	17.90	5,613	1,040	18.53
55-64	162	19	11.73	5,613	533	9.50
65-74	162	0	0.00	5,613	90	1.60
75o	162	0	0.00	5,613	14	0.25
Sex						
Male	162	85	52.47	5,613	2,286	40.73
Female	162	77	47.53	5,613	3,327	59.27
Location						
ACT	162	0	0	5,613	73	1.30
NSW	162	44	27.16	5,613	1,568	27.94
NT	162	0	0	5,613	27	0.48
QLD	162	46	28.40	5,613	989	17.62
SA	162	12	7.41	5,613	503	8.96
TAS	162	9	5.56	5,613	115	2.05
VIC	162	37	22.84	5,613	1,776	31.64

	Podiatrist survey results [1]			**PBA registrant data [2]**		
	N	**n**	**%**	**N**	**n**	**%**
WA	162	13	8.02	5,613	490	8.73

Source: 1. Podiatrist survey; and 2. Podiatry Board of Australia (2020)

PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Schedule of Pharmaceutical Benefits;

FINANCIAL IMPACT ANALYSIS

ESTIMATION OF USE FROM PODIATRIST PRESCRIBING

A market-share approach was used to estimate the predicted use and financial implications of subsidising podiatrist prescriptions under Section 88 of the National Health Act. Key assumptions underpinning the FIA include:

- Prescription rates observed in the podiatrist survey are applicable to the Australian population of podiatrists
- The mean number of scripts for each podiatrist (calculated using the survey) is maintained over the time-horizon

The number of national podiatrist prescribers was forecast over 6 years from 2021 to 2026 (Table 2). Historical data from the Podiatry Board of Australia (from 2016 to 2020) was used to establish trend lines for endorsed general and surgeon podiatrists, separately (using Excel version 16.44). The number of national podiatrist prescribers was then extrapolated for 6 years from 2021 to 2026.

A scenario analysis was also conducted to calculate the FIA if endorsement uptake were increased due to increased interest in accreditation following PBS-subsidy. This is presented in the section on Identification, estimation, and reduction of uncertainty.

The average number of scripts for each medicine was estimated using the survey and extrapolated to all prescribing podiatrists in Australia (Table 2). Podiatrists who are endorsed to prescribe may prescribe from the National podiatry scheduled medicines list which is maintained by the Podiatry Board of Australia (2018). The following process was used to estimate national script volumes:

- Survey respondents entered their prescribing volume for each medication in the National podiatry schedule. This was one of the final questions in the survey. In order to minimise survey fatigue, respondents were only presented medications from classes which they usually prescribe (asked in a separate survey question). The list of medicines presented to each respondent was also dependent on registration type (General or Surgeon).
- Mean prescription rates for each medication were multiplied by the national number of general endorsed and surgeon podiatrists in each strata.

- The total number of prescriptions was combined and multiplied by 12 (to estimate yearly script volumes)

A proportion of scripts written by podiatrists are currently redirected to a PBS-eligible prescriber (such as GP). The number of incremental scripts applicable to the PBS, estimated based on the proportion of scripts which are written directly by the podiatrist, was determined in the survey as no publicly data were available (Table 2). This data was estimated based on The incremental financial impact to the PBS is expected to come from scripts which are currently not redirected and dispensed as private. The proportion of direct/redirected scripts was asked in the survey (see Methodology Section).

Table 2: Estimated number of incremental scripts for the PBS/RPBS from podiatry prescribing

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
A. Historical number of podiatrists											
Total, n	4,569.00	4,835.00	5,064.00	5,251.00	5,470.00	-	-	-	-	-	-
Endorsed to prescribe, n	76.00	82.00	99.00	114.00	144.00	-	-	-	-	-	-
% Change	-	7.89%	20.73%	15.15%	26.32%	-	-	-	-	-	-
Surgeons, n	31.00	31.00	35.00	34.00	36.00	-	-	-	-	-	-
% Change		0.00%	12.90%	-2.86%	5.88%	-	-	-	-	-	-
General endorsed, n	45.00	51.00	64.00	80.00	108.00	-	-	-	-	-	-
% Change		13.33%	25.49%	25.00%	35.00%	-	-	-	-	-	-
B. Forecast number of podiatrists											
General endorsed, n	-	-	-	-	108.00	116.10	131.60	147.10	162.60	178.10	193.60
% Change	-	-	-	-	35.00%	7.50%	13.35%	11.78%	10.54%	9.53%	8.70%
Surgeons, n	-	-	-	-	36.00	37.30	38.60	39.90	41.20	42.50	43.80
% Change	-	-	-	-	5.88%	3.61%	3.49%	3.37%	3.26%	3.16%	3.06%
Total prescribers, n	-	-	-	-	144.00	153.40	170.20	187.00	203.80	220.60	237.40
% Change	-	-	-	-	26.32%	6.53%	10.95%	9.87%	8.98%	8.24%	7.62%
C. Forecast number of national scripts [a]											
Total general endorsed scripts	-	-	-	-	19,333.99	20,784.04	23,558.82	26,333.61	29,108.39	31,883.18	34,657.96
Total surgeon scripts	-	-	-	-	32,006.66	33,162.46	34,318.26	35,474.05	36,629.85	37,785.65	38,941.44
Total scripts	-	-	-	-	51,340.65	53,946.50	57,877.08	61,807.66	65,738.24	69,668.82	73,599.40
D. Forecast number of national scripts which are direct/redirected [a]											
Direct scripts	-	-	-	-	34,454.71	36,203.49	38,841.31	41,479.12	44,116.93	46,754.75	49,392.56

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Hospital redirected scripts	-	-	-	-	8,684.34	9,125.13	9,789.99	10,454.85	11,119.72	11,784.58	12,449.44
Primary care redirected scripts	-	-	-	-	8,201.60	8,617.88	9,245.78	9,873.69	10,501.59	11,129.49	11,757.40

Source: Podiatrist data from 2016 to 2020 sourced from Podiatry Board of Australia (2020)

PBS = Pharmaceutical

[a] Script numbers are presented above as aggregate. Script numbers for individual medicines are outlined in the accompanying Budget Impact Analysis Excel workbook.

ESTIMATION OF FINANCIAL IMPACT FROM PODIATRIST PRESCRIBING

The total cost to the PBS/RPBS was estimated based on the incremental scripts expected from podiatry prescribing. The average dispensed price for maximum quantity (DPMQ) for each medicine in the survey was sourced from the PBS website and included December 2020 values. The total cost of medications over 6 years was expected to be $7,392,851 (Table 3).

The cost after patient co-pay (patient contribution amount) was calculated for each medication to ensure no individual medication costs fall below $0. For each medication, the cost after co-pay was calculated based on General, Concession, and DVA patient co-pay amounts. The proportion of patients seen by podiatrists in each patient category was 69.22%, 24.54%, and 6.23%, respectively based on survey-respondent feedback. These proportions were then used to calculate the weighted-average cost for each medication after patient co-pay. The total patient co-payments over the 6-year period was estimated to be $4,531,639 (Table 3).

Excluding patient co-payments, the total financial impact for podiatry prescribing over 6 years from 2021 to 2026 was estimated to be $2,861,212 (Table 3).

Table 3: Estimated net cost of podiatrist prescribing to the PBS/RPBS

	2021	**2022**	**2023**	**2024**	**2025**	**2026**	**Total**
Estimated # of Scripts issued by Podiatrists/ Surgeons	36,203	38,841	41,479	44,116	46,755	49,393	256,788
Total cost of all Podiatry prescribed PBS/RPBS scripts	$1,012,088	$1,100,109	$1,188,131	$1,276,153	$1,364,174	$1,452,196	$7,392,851
Total patient co-payments	$631,896	$681,247	$730,598	$779,949	$829,300	$878,651	$4,531,639
PBS/RPBS total minus co-pay	$380,192	$418,863	$457,533	$496,204	$534,875	$573,545	$2,861,212

Source: Prices for each medication were obtained from 1st December, 2020 DPMQ values (PBS, 2020); Note: See Budget Impact Analysis workbook for individual medication costs

ESTIMATION OF CHANGES IN USE AND FINANCIAL IMPACT OF OTHER MEDICINES

As only incremental scripts (all scripts excluding those that are already redirected to a PBS-eligible prescriber) were considered in the FIA, there was not expected to be any change in the financial impact of other medicines.

ESTIMATION FINANCIAL IMPLICATIONS FOR THE HEALTH BUDGET

Net prescription processing changes for the DHS

It was expected that podiatry prescribing will result in increased DHS prescription processing for medicines which are deemed to require Authority approvals.

"Authority-Required" scripts require specific criteria to be met and verified by the DHS – hence a small processing fee might apply in each case. The number of podiatry scripts which may require this is uncertain as it will depend on the restrictions (if any) that the PBAC apply if podiatry scripts become PBS-endorsed.

Net financial implications for the MBS

The availability of PBS-subsidy to podiatrist prescriptions is expected to be associated with an MBS-fee cost-offset. A proportion of podiatry scripts are currently redirected to a primary-care prescriber in order for patients to receive PBS-subsidy. These consultations are associated with an MBS (item 23) fee of $38.75 each. The inclusion of PBS-subsidy for podiatrist scripts will remove the need for patients to be redirected to primary-care prescribers; hence will be associated with cost-offset to the health budget. Consultation-fees for podiatrists are not expected to change.

The number of primary care consultations to be offset was calculated by adjusting the number of scripts redirected to eligible primary care prescribers by the average number of scripts per visit. The number of scripts per visit was not available in public literature, however, was estimated to range from 1 to 2 (based on separate consultations with prescribing podiatrists). For the base-case we assumed the number of scripts per visit to be 1.5. Further scenarios are tested in the section on Identification, estimation, and reduction of uncertainty.

The cost-offset for the MBS over 6 years is expected to be $1,579,084. The total impact of podiatry prescribing on the health budget including offsets from patient co-payments and MBS-fees is expected to be $1,282,128 (Table 4).

Table 4: Total impact of podiatry prescribing to the health budget

	2021	2022	2023	2024	2025	2026	Total
Scripts redirected to GP	8,618	9,246	9,874	10,502	11,129	11,757	61,126
Patients redirected to GP	5,745	6,164	6,582	7,001	7,420	7,838	40,751
Incremental MBS fee	$222,628	$238,849	$255,070	$271,291	$287,512	$303,733	$1,579,084
PBS/RPBS total	$1,012,088	$1,100,109	$1,188,131	$1,276,153	$1,364,174	$1,452,196	$7,392,851
PBS/RPBS total minus MBS offset	$789,459	$861,260	$933,061	$1,004,862	$1,076,662	$1,148,463	$5,813,767
PBS/RPBS total minus MBS offset and patient co-pay	$157,563	$180,013	$202,463	$224,913	$247,363	$269,813	$1,282,128

MBS = Medicare Benefits Schedule; PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Schedule of Pharmaceutical Benefits; Note: An MBS item cost of $38.75 (MBS item 23) was used to calculate associated cost-offset

IDENTIFICATION, ESTIMATION, AND REDUCTION OF UNCERTAINTY

A number of scenario analyses were conducted in order to test uncertainty in the base-case estimates. These results have been presented in Table 6.

In Scenario A, an additional increase in accreditation of 69.64% was applied to the projected number of accredited podiatrist prescribers in the base-case. This value was taken from the proportion of respondents who indicated they would consider accreditation if scripts written by podiatrists were PBS-subsidised. The increase in accreditation was applied over 4 years to account for national training capacity. The 6-year financial impact in Scenario A was $2,064,181; an increase of $782,053 compared with the base-case.

Scenario B tested the financial impact of changes in the proportion of patients redirected to primary care prescribers. This will influence the MBS offset amount as well as the total number of incremental scripts expected to impact the PBS/RPBS. Scenario B1 and B2 replace the mean proportion of redirected patients obtained in the survey with the 95% confidence interval upper and lower values, respectively. The 6-year financial impact of these scenarios were $117,331 and $2,447,832, respectively. Compared with the base-case, these scenarios represent a cost-saving of $1,164,797 and an additional cost of $1,165,704 in each scenario, respectively.

Scenario C utilised constrained means in calculating the mean number of scripts written for each medication. The constrained means value excludes extreme values which fall in the 5th and 95th percentiles, respectively. This scenario was tested in order to reduce the average

script numbers for each prescriber, which was identified as an overestimation during analysis. The constrained means method brought the average number of prescriptions down to 24 scripts/prescriber/month compared with approximately 30 scripts/prescriber/month in the base case. This scenario resulted in a total financial impact of $754,799 over 6 years; a saving of $527,329 compared with the base case.

Scenario D tested the impact of adjusting average medications per visit to a redirected GP. The MBS cost-offset was based on GP consultations avoided – which in turn was dependent on how many medications each patient brought to the GP on average. Based on consultations with podiatrist prescribers, this value is expected to range from 1 to 2 in clinical practise. The resulting 6-year financial impact is expected to range from $492,586 to $1,676,899, respectively. The relative difference compared with the base case ranged from a saving of $789,542 to an additional cost of $394,771, respectively.

Table 5: Podiatrist prescribing financial impact scenario analyses

Scenario	Description	Financial impact after patient co-pay and MBS offsets	Change in financial impact compared with base-case
Base-case	-	$1,282,128	-
A	Increased accreditation of 69.64% over years 2021 to 2024. This was the proportion of non-prescribing respondents who indicated they would be interested in becoming accredited if PBS-subsidy were available	$2,064,181	$782,053
B1	Upper limit for 95% confidence interval in the proportion of scripts that are currently prescribed directly by a podiatrist (80.93%)	$117,331	*($1,164,797)*
B2	Lower limit for 95% confidence interval in the proportion of scripts that are currently prescribed directly by a podiatrist (56.31%)	$2,447,832	$1,165,704
C	The 5% trimmed mean value is utilised for number of scripts prescribed for each medication	$754,799	*($527,329)*
D1	The number of prescriptions per visit of a primary-care prescriber is changed to 1	$492,586	*($789,542)*
D2	The number of prescriptions per visit of a primary-care prescriber is changed to 2	$1,676,899	$394,771

Note: Budget Impact Analysis workbooks have been presented for each scenario.
Note: All values italicised and presented in brackets indicate a negative value (cost-saving compared with base-case); MBS = Medicare Benefits Schedule; PBS = Pharmaceutical Benefits Scheme;

Cost-offsets not considered in the financial impact analysis

It is likely that additional cost-offsets would be achieved from hospital-based podiatrist-prescribers. The survey identified that 25% of scripts would be redirected to PBS-eligible prescribers in the hospital. These redirected scripts require hospital resources which would be avoided if podiatrists could directly prescribe PBS-eligible scripts.

Patients who have delayed treatment to podiatric conditions while waiting to see a PBS-eligible prescriber may have complications and require more health resources. Some of these treatment-delays (and associated complications) could be avoided if podiatrists could directly prescribe PBS-eligible scripts. Qualitative feedback provided in the survey provided a strong emphasis regarding avoided treatment-delays.

QUALITY USE OF MEDICINES

Respondents contributed a number of important quality use of medicines considerations in the survey. The majority of respondents indicated that inclusion of podiatrists in PBS-prescribing would lead to clinical benefits for patients. The primary reasons for this include: 1) reduced time-to-treatment for patients required to wait for a GP; and 2) improved access to medications due to patient affordability. Currently patients who can't afford a private script are redirected to a GP. As mentioned by a number of respondents, in rural or remote areas the delay in seeing a GP may equate to a number of days or weeks in waiting for patients. The delay in access to treatment may have a substantial impact on patients' health for conditions such as foot ulcers - which require urgent attention.

The increased affordability for patients would also likely improve adherence to medications. Respondents in the survey identified that approximately 7.3% (95% CI: 4.4%, 10.3%) of scripts written by podiatrists and podiatric surgeons go unfilled by patients. This would be expected to reduce given improved affordability for patients.

Respondents also mentioned that inclusion of podiatry scripts on the PBS will bring greater understanding outside of the profession. This will bring podiatry in line with other non-medical health practitioners who are able to prescribe, including dentists, nurse practitioners, and optometrists. This will also help avoid delays in script-dispensing which often arise due to lack of awareness of podiatry prescribing among pharmacists.

A number of respondents identified that inclusion on the PBS will enable greater monitoring of scripts written by podiatrists. This is required for monitoring of important health initiatives. Some of these include the Opioid Stewardship program, Prescription Shopping Programme, and the Antimicrobial Stewardship program. All of these programs rely on PBS statistics for community scripts. However, the current prescribing pathway for podiatrists – as private scripts – is not captured in PBS statistics. There are a number of negative outcomes as a result of this. Some of which include: 1) Podiatrists face substantial professional development inequities as a result of limited prescribing-oversight and influence from quality improvement initiatives; 2) The validity of PBS-data collection, analysis, and reporting for health initiatives is limited by missing data from the podiatry profession; and 3) Podiatrists are not able to assess the suitability of their patients for drugs of dependence to the same capacity as other prescribing professions.

APPENDIX 1 DATA CLEANING AND PRESCRIPTION UNCERTAINTY

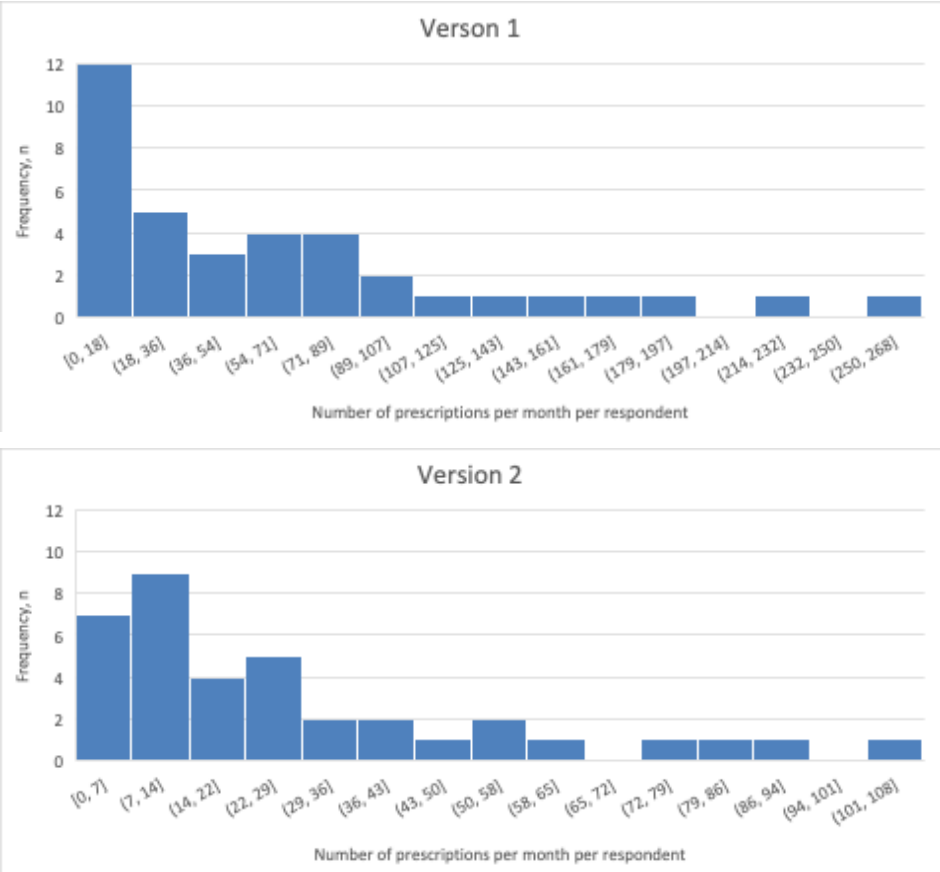
Following the final data cut (14th December 2020), the data were cleaned and organised using SPSS (Version 27). This included:

- Variables were given appropriate names
- Labels were created for categorical variables (such as age categories and sex)
- Full entries with incomplete/inappropriate data were removed from the dataset
- Entries for individual variables which were considered nonsensical were removed from the dataset.

Once the data were organised, preliminary analyses were conducted on the data to explore central tendency and spread of responses. The dataset at this point (Version 1) indicated the average number of scripts/month/prescribing podiatrist was 64 – which was considered to be substantially higher than what would be expected in reality. Further, a histogram of the distribution of total scripts/month indicated a substantial skew and outliers to the right (**Error! Reference source not found.** – Version 1).

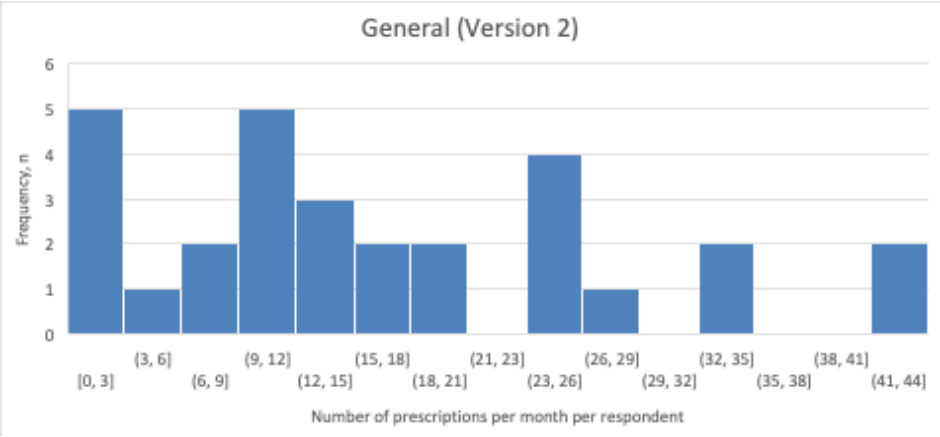
In order to handle outliers, a Z-distribution was produced for each medication. Responses which were more than +/- 2 z-scores from the mean were identified as outliers and removed from the analysis. A z-score of 2 was considered an appropriate outlier threshold to preserve responses in a small survey. This was done separately for general and surgical podiatrists as prescription numbers varied substantially between these groups. Following these changes, the dataset shifted to a more parametric shape, however, there was still a substantial skew to the right (**Error! Reference source not found.** – Version 2).

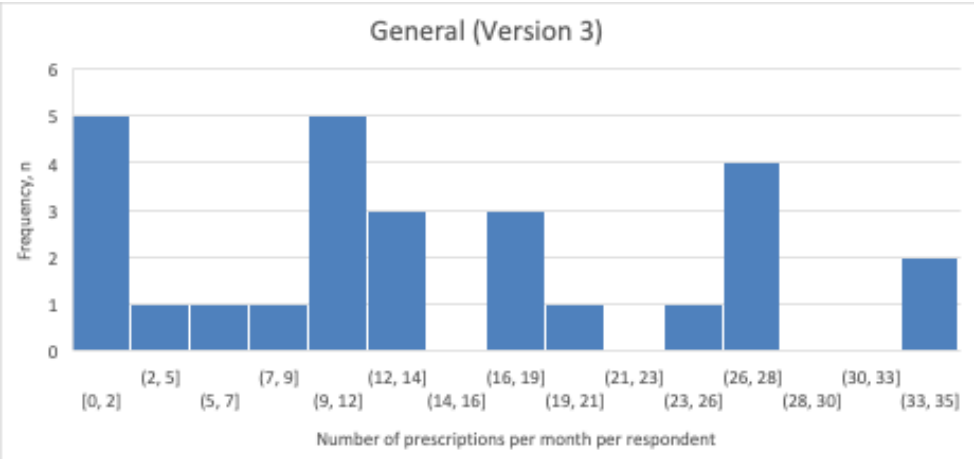
Figure 1: Distribution of survey responses by prescribing quantity per month



Following the identification of outliers in individual medication fields, the dataset was interrogated for outliers based on total respondent prescribing. Respondents who had a total prescribing number +/- 2 z-scores from the mean were removed from the analysis. This was done separately for general and surgical podiatrists as prescription numbers varied substantially between these groups. Only two respondents in the general podiatrist prescribers group fit these criteria. The change in distribution for general podiatrist prescriptions shifted towards the mean.

Figure 2: Distribution of general podiatrist prescription quantity per month





Overall, the final prescription distribution indicates there is still a skew towards the right. Following removal of outliers, the average prescription volume per prescribing podiatrist dropped from 64.3 (SD: 66.4) scripts per month to 29.7 (SD: 28.3) scripts per month. Based on focussed consultations with prescribing podiatrists, this figure was still considered to be high. It was considered that due to recall bias, respondents tended to overstate their prescribing volumes. Despite this, it was considered that a financial impact analysis constructed using overstated prescription numbers was still informative to Department of Health decision making.

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ATTACHMENT 1 SURVEY DESIGN

PBAC financial impact section	Considerations	Data source
4.1 Justification of data sources	NA	Review of available literature
4.2 Use and costs: (Define proportion of market share approach) which is associated with podiatrist prescribing	Total market size	PBS Statistics
	Number of scripts which would be expected from podiatrist prescribing. • Some medicines may only be prescribed by podiatric surgeons • Need to define projected growth over 6 years • Patients may be General, General-concession, or RPBS-eligible (with DVA) • Scripts currently may be re-directed to PBS-eligible prescriber	PBA
		Prescriber type (Question 9)
		Prescriber attitude (Question 11)
		Patient-concession (Question 12)
		Script redirection (Question 13)
		Podiatrist prescribing (Question 14)
	Cost of prescribed medications	DPMQ – PBS website
4.3 Changes to other medicines	The number of referred scripts (to GP and hospital) prescribers) would currently be subsidised through the PBS. The total cost of these will need to be calculated	Script redirection (Question 13) and Podiatrist prescribing (Question 14)
		DPMQ – PBS website
4.4 Financial implications for the PBS	Total cost (4.2) – Changes to other medications (4.3)	-
4.5 Financial implications for the Australian Government	The number of scripts referred to GP will be associated with an MBS fee	Script redirection (Question 13) and Podiatrist prescribing (Question 14)

PBAC financial impact section	Considerations	Data source
	Uncertainty in applicability of the sample to the full population of podiatrist prescribers	Questions 1 to 10
	Uncertainty due to sample size	-
4.7 Quality use of medicines	Consider important considerations such as repeats, maximum quantity dispensed (to align with NPS), PBS restrictions and how they relate to podiatrist prescribing	-

DPMQ = Dispensed price for maximum quantity; DVA = Department of Veterans Affairs; NPS = National podiatry schedule; PBA = Podiatry Board of Australia; PBS = Pharmaceutical Benefits Scheme; RPBS = Repatriation Pharmaceutical Benefits Schedule.
Note: Type (in isolation) refers to podiatrist accreditation: Non-prescribing; prescribing non-surgeon; prescribing surgeon

ATTACHMENT 2 SURVEY QUESTIONS

Please answer each of the following questions by clicking on the most appropriate response for your primary role (where you worked most frequently over the past 12 months):

1. What is your age group? *<forced response, one answer only (as displayed below) or numeric answer box>*
    a. <25 years
    b. 25-29 years
    c. 30-34 years
    d. 35 – 39 years
    e. 40-44 years
    f. 45 – 49 years
    g. 50-54 years
    h. 55 – 59 years
    i. 60 years and over
2. Please select the state or territory where you practice most frequently: *<forced response>*
    a. Australian Capital Territory
    b. New South Wales
    c. Northern Territory
    d. Queensland
    e. South Australia
    f. Tasmania
    g. Victoria
    h. Western Australia
3. Please select the principal role where you work most frequently: *<forced response, one answer only>*
    a. Clinician
    b. Administrator

   c. Teacher or educator
   d. Researcher
   e. Other

4. Please select your principal work sector: *<forced response, one answer only>*
   a. Public sector
   b. Private sector
   c. Both public and private
5. Please select the principal work setting: *<forced response, one answer only>*
   a. Group private practice Solo private practice
   b. Other community health care service Outpatient service
   c. Residential aged care facility
   d. Hospital
   e. Education facility Sports centre/clinic
   f. Other locum private practice
   g. Aboriginal health service
   h. Other
6. Please select the primary location you work in: *<forced response, one answer only>*
   a. Metropolitan
   b. Inner Regional centre
   c. Outer Regional centre
   d. Remote
   e. Very remote communities
7. 9. How long have you been practising as a podiatrist or podiatric surgeon: *<forced response, one answer only>*
   a. 0 – 4 years
   b. 5 – 9 years
   c. 10 – 14 years
   d. 14 - 19 years

e. More than 20 years

8. *Prescribing podiatrists only* - Please enter the length of time (in years) which you have held an endorsement for scheduled medicines <*text entry*>

    a. *"X" years*

9. What is your profession? <*forced choice, one answer only*>

    a. Non-prescribing podiatrist

    b. Prescribing non-surgical podiatrist

    c. Prescribing podiatric Surgeon

10. *Prescribing podiatrists only* - Please enter the length of time (in years) which you have held an endorsement for scheduled medicines <*text entry*>

    a. *"X" years*

11. *Non-prescribing podiatrists only* – If the National podiatry schedule were reimbursed under the PBS, would you consider becoming accredited? <*forced choice, one answer only*>

    a. Yes

    b. Maybe

    c. No

12. Please indicate the proportion (as a percentage) of patients you see by general/concession/Department of Veterans Affairs (DVA)? < *numeric answer boxes with a fixed "%" symbol. Ensure total must come to 100%*>

    a. X% of my patients are general

    b. X% of my patients are concessional

    c. X% of my patients are DVA

13. *Prescribing-podiatrist only* – What proportion of your prescriptions would you say are redirected to PBS-eligible prescribers? <*numeric answer boxes with a fixed "%" symbol. Ensure total must come to 100%*>

    a. X% of my scripts are not filled

    b. X% of my scripts are paid for in-full as private script

    c. X% of my scripts are redirected to a hospital prescriber (e.g. registrar)

    d. X% of my scripts are redirected to a primary care GP

14. *Prescribing podiatrists only* – Please indicate, on average, how many scripts you write for each of the medications below. Include scripts you write yourself and scripts you refer to other prescribers (such as GPs or Registrars). <*This may follow a sequential or block approach*>.

    Please see Appendix 1 for description of the sequential and block approach

15. Are there any other comments you would like to add? <*Free-entry text box*>

ATTACHMENT 3 NATIONAL PODIATRY SCHEDULED MEDICINES LIST

Table 6: Medicines for general podiatrists with an endorsement for scheduled medicines.

Category	**Medicines**
Allergy and anaphylaxis	fexofenadine hydrochloride 120 mg tablet, 30
	fexofenadine hydrochloride 60 mg tablet, 20
	loratadine 10 mg tablet, 30
Analgesics	codeine phosphate hemihydrate 30 mg tablet, 20
	paracetamol 120 mg/5 mL oral liquid, 100 mL
	paracetamol 240 mg/5 mL oral liquid, 200 mL
	paracetamol 500 mg tablet, 100
	paracetamol 665 mg modified release tablet, 192
	paracetamol 665 mg modified release tablet, 96
Antibacterials	amoxicillin 1 g tablet, 14
	amoxicillin 100 mg/mL powder for oral liquid, 20 mL
	amoxicillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL powder for oral liquid, 75 mL
	amoxicillin 125 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 250 mg capsule, 20
	amoxicillin 250 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL powder for oral liquid, 60 mL
	amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10
	amoxicillin 500 mg capsule, 20
	amoxicillin 500 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10
	cefalexin 125 mg/5 mL powder for oral liquid, 100 mL
	cefalexin 250 mg capsule, 20
	cefalexin 250 mg/5 mL powder for oral liquid, 100 mL
	cefalexin 500 mg capsule, 20
	ciprofloxacin 250 mg tablet, 14
	ciprofloxacin 500 mg tablet, 14
	ciprofloxacin 750 mg tablet, 14
	clindamycin 150 mg capsule, 24
	dicloxacillin 250 mg capsule, 24
	dicloxacillin 500 mg capsule, 24
	flucloxacillin 125 mg/5 mL powder for oral liquid, 100 mL
	flucloxacillin 250 mg capsule, 24
	flucloxacillin 250 mg capsule, 28
	flucloxacillin 250 mg/5 mL powder for oral liquid, 100 mL
	flucloxacillin 500 mg capsule, 100

Category	**Medicines**
	flucloxacillin 500 mg capsule, 24
	metronidazole 200 mg tablet, 21
	metronidazole 200 mg/5 mL oral liquid, 100 mL
	metronidazole 400 mg tablet, 21
	metronidazole 500 mg suppository, 10
	roxithromycin 150 mg tablet, 10
	roxithromycin 300 mg tablet, 5
	roxithromycin 50 mg dispersible tablet, 10
Antifungals	griseofulvin 125 mg tablet, 100
	griseofulvin 500 mg tablet, 28
	terbinafine 1% gel, 15 g
	terbinafine 250 mg tablet, 42
	terbinafine hydrochloride 1% cream, 15 g
Corticosteroids and drugs for eczema	betamethasone (as dipropionate) 0.05% cream, 15 g
	betamethasone (as dipropionate) 0.05% ointment, 15 g
	betamethasone (as valerate) 0.02% cream, 100 g
	betamethasone (as valerate) 0.05% cream, 15 g
	betamethasone (as valerate) 0.1% cream, 30 g
	betamethasone (as valerate) 0.1% ointment, 30 g
	dexamethasone phosphate 8 mg/2 mL injection, 5 x 2 mL vials
	dexamethasone sodium phosphate Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5
	hydrocortisone acetate 1% cream, 30 g
	hydrocortisone acetate 1% cream, 50 g
	hydrocortisone acetate 1% ointment, 30 g
	hydrocortisone acetate 1% ointment, 50 g
	methylprednisolone 1 g injection, 1 vial
	methylprednisolone 40 mg injection [1 vial] (&) inert substance diluent [1 mL vial], 1 pack
	methylprednisolone 40 mg injection, 5 vials
	methylprednisolone aceponate 0.1% cream, 15 g
	methylprednisolone aceponate 0.1% lotion, 20 g
	methylprednisolone aceponate 0.1% ointment, 15 g
	mometasone furoate 0.1% cream, 15 g
	mometasone furoate 0.1% cream, 50 g
	mometasone furoate 0.1% lotion, 30 mL
	mometasone furoate 0.1% ointment, 15 g
	mometasone furoate 0.1% ointment, 50 g
	triamcinolone acetonide 0.02% cream, 100 g
	triamcinolone acetonide 0.02% ointment, 100 g
	triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules
	lidocaine (lignocaine) hydrochloride 10% (500 mg/5 mL) injection, 10 x 5 mL ampoules

Category	Medicines
General and local anaesthetics	lidocaine (lignocaine) hydrochloride monohydrate 1% (50 mg/5 mL) injection, 5 x 5 mL ampoules
	methoxyflurane 99.9% (999 mg/g) inhalation solution, 3 mL bottle
NSAIDs and drugs for gout	celecoxib 100 mg capsule, 60
	celecoxib 200 mg capsule, 30
	colchicine 500 microgram tablet, 30
	ibuprofen 400 mg tablet, 30
	indomethacin 25 mg capsule, 50
	meloxicam 15 mg tablets or capsules, 30
	meloxicam 7.5 mg tablets or capsules, 30
	naproxen 1 g modified release tablet, 28
	naproxen 125 mg/5 mL oral liquid, 474 mL
	naproxen 250 mg tablet, 50
	naproxen 500 mg tablet, 50
	naproxen 750 mg modified release tablet, 28
	naproxen sodium 550 mg tablet, 50
Topical drugs for skin infections	amorolfine 5% solution, 5 mL
	clotrimazole 1% cream, 20 g
	diclofenac sodium 3% gel, 25 g
	ketoconazole 1% shampoo, 100 mL
	ketoconazole 2% cream, 30 g
	ketoconazole 2% shampoo, 60 mL
	miconazole 2% solution, 30 mL
	miconazole nitrate 2% cream, 30 g
	miconazole nitrate 2% cream, 70 g
	miconazole nitrate 2% powder, 30 g
	mupirocin 2% cream, 15 g
	mupirocin 2% ointment, 15 g
	mupirocin 2% ointment, 3 g
	mupirocin 2% ointment, 5 g
	silver sulfadiazine 1% cream, 50 g
Wounds	Dressing foam with silver

Table 7: Medicines for podiatric surgeons with an endorsement for scheduled medicines

Category	Drug
Allergy and anaphylaxis	adrenaline (epinephrine) 1 in 1000 (1 mg/mL) injection, 5 x 1 mL ampoules
	adrenaline (epinephrine) 150 microgram/0.3 mL injection, 0.3 mL pen device
	adrenaline (epinephrine) 300 microgram/0.3 mL injection, 0.3 mL pen device
	fexofenadine hydrochloride 120 mg tablet, 30

Category	**Drug**
	fexofenadine hydrochloride 60 mg tablet, 20
	loratadine 10 mg tablet, 30
Analgesics and opioid reversal	codeine phosphate hemihydrate 30 mg tablet, 20
	naloxone hydrochloride 1 mg/mL injection, 2 mL syringe
	naloxone hydrochloride 400 microgram/mL injection, 10 x 1 mL ampoules
	naloxone hydrochloride 400 microgram/mL injection, 5 x 1 mL ampoules
	oxycodone hydrochloride 1 mg/mL oral liquid, 250 mL
	oxycodone hydrochloride 10 mg capsule, 20
	oxycodone hydrochloride 5 mg capsule, 20
	oxycodone hydrochloride 5 mg tablet, 20
	paracetamol 120 mg/5 mL oral liquid, 100 mL
	paracetamol 240 mg/5 mL oral liquid, 200 mL
	paracetamol 500 mg tablet, 100
	paracetamol 665 mg modified release tablet, 192
	paracetamol 665 mg modified release tablet, 96
Antibacterials	amoxicillin 1 g tablet, 14
	amoxicillin 100 mg/mL powder for oral liquid, 20 mL
	amoxicillin 125 mg/5 mL + clavulanic acid 31.25 mg/5 mL powder for oral liquid, 75 mL
	amoxicillin 125 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 250 mg capsule, 20
	amoxicillin 250 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 400 mg/5 mL + clavulanic acid 57 mg/5 mL powder for oral liquid, 60 mL
	amoxicillin 500 mg + clavulanic acid 125 mg tablet, 10
	amoxicillin 500 mg capsule, 20
	amoxicillin 500 mg/5 mL powder for oral liquid, 100 mL
	amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10
	cefalexin 125 mg/5 mL powder for oral liquid, 100 mL
	cefalexin 250 mg capsule, 20
	cefalexin 250 mg/5 mL powder for oral liquid, 100 mL
	cefalexin 500 mg capsule, 20
	ciprofloxacin 250 mg tablet, 14
	ciprofloxacin 500 mg tablet, 14
	ciprofloxacin 750 mg tablet, 14
	clindamycin 150 mg capsule, 24
	dicloxacillin 250 mg capsule, 24
	dicloxacillin 500 mg capsule, 24
	doxycycline 100 mg modified release capsule, 21
	doxycycline 100 mg modified release capsule, 7
	doxycycline 100 mg tablet, 21
	doxycycline 100 mg tablet, 7
	doxycycline 50 mg modified release capsule, 25
	doxycycline 50 mg tablet, 25

Category	**Drug**
	erythromycin (as ethyl succinate) 200 mg/5 mL powder for oral liquid, 100 mL
	erythromycin (as ethyl succinate) 400 mg tablet, 25
	erythromycin (as ethyl succinate) 400 mg/5 mL powder for oral liquid, 100 mL
	erythromycin 250 mg enteric capsule, 25
	flucloxacillin 1 g injection, 10 vials
	flucloxacillin 1 g injection, 5 vials
	flucloxacillin 125 mg/5 mL powder for oral liquid, 100 mL
	flucloxacillin 250 mg capsule, 24
	flucloxacillin 250 mg capsule, 28
	flucloxacillin 250 mg/5 mL powder for oral liquid, 100 mL
	flucloxacillin 500 mg capsule, 100
	flucloxacillin 500 mg capsule, 24
	metronidazole 200 mg tablet, 21
	metronidazole 200 mg/5 mL oral liquid, 100 mL
	metronidazole 400 mg tablet, 21
	metronidazole 500 mg suppository, 10
	phenoxymethylpenicillin 125 mg/5 mL powder for oral liquid, 100 mL
	phenoxymethylpenicillin 150 mg/5 mL oral liquid, 100 mL
	phenoxymethylpenicillin 250 mg capsule, 50
	phenoxymethylpenicillin 250 mg tablet, 25
	phenoxymethylpenicillin 250 mg/5 mL powder for oral liquid, 100 mL
	phenoxymethylpenicillin 500 mg capsule, 50
	phenoxymethylpenicillin 500 mg tablet, 25
	roxithromycin 150 mg tablet, 10
	roxithromycin 300 mg tablet, 5
	roxithromycin 50 mg dispersible tablet, 10
Antifungals	griseofulvin 125 mg tablet, 100
	griseofulvin 500 mg tablet, 28
	terbinafine 1% gel, 15 g
	terbinafine 250 mg tablet, 42
	terbinafine hydrochloride 1% cream, 15 g
Benzodiazepines	diazepam 2 mg tablet, 50
	diazepam 5 mg tablet, 50
Corticosteroids and drugs for eczema	betamethasone (as dipropionate) 0.05% cream, 15 g
	betamethasone (as dipropionate) 0.05% ointment, 15 g
	betamethasone (as valerate) 0.02% cream, 100 g
	betamethasone (as valerate) 0.05% cream, 15 g
	betamethasone (as valerate) 0.1% cream, 30 g
	betamethasone (as valerate) 0.1% ointment, 30 g
	dexamethasone phosphate 8 mg/2 mL injection, 5 x 2 mL vials
	dexamethasone sodium phosphate Injection equivalent to 4 mg dexamethasone phosphate in 1 mL, 5

Category	**Drug**
	hydrocortisone acetate 1% cream, 30 g
	hydrocortisone acetate 1% cream, 50 g
	hydrocortisone acetate 1% ointment, 30 g
	hydrocortisone acetate 1% ointment, 50 g
	methylprednisolone 1 g injection, 1 vial
	methylprednisolone 40 mg injection [1 vial] (&) inert substance diluent [1 mL vial], 1 pack
	methylprednisolone 40 mg injection, 5 vials
	methylprednisolone aceponate 0.1% cream, 15 g
	methylprednisolone aceponate 0.1% lotion, 20 g
	methylprednisolone aceponate 0.1% ointment, 15 g
	mometasone furoate 0.1% cream, 15 g
	mometasone furoate 0.1% cream, 50 g
	mometasone furoate 0.1% lotion, 30 mL
	mometasone furoate 0.1% ointment, 15 g
	mometasone furoate 0.1% ointment, 50 g
	triamcinolone acetonide 0.02% cream, 100 g
	triamcinolone acetonide 0.02% ointment, 100 g
	triamcinolone acetonide 10 mg/mL injection, 5 x 1 mL ampoules
General and local anaesthetics	lidocaine (lignocaine) hydrochloride 10% (500 mg/5 mL) injection, 10 x 5 mL ampoules
	lidocaine (lignocaine) hydrochloride monohydrate 1% (50 mg/5 mL) injection, 5 x 5 mL ampoules
	methoxyflurane 99.9% (999 mg/g) inhalation solution, 3 mL bottle
NSAIDs and drugs for gout	celecoxib 100 mg capsule, 60
	celecoxib 200 mg capsule, 30
	colchicine 500 microgram tablet, 30
	ibuprofen 400 mg tablet, 30
	indomethacin 100 mg suppository, 20
	indomethacin 25 mg capsule, 50
	meloxicam 15 mg tablets or capsules, 30
	meloxicam 7.5 mg tablets or capsules, 30
	naproxen 1 g modified release tablet, 28
	naproxen 125 mg/5 mL oral liquid, 474 mL
	naproxen 250 mg tablet, 50
	naproxen 500 mg tablet, 50
	naproxen 750 mg modified release tablet, 28
	naproxen sodium 550 mg tablet, 50
Topical drugs for skin infections	amorolfine 5% solution, 5 mL
	clotrimazole 1% cream, 20 g
	diclofenac sodium 3% gel, 25 g
	ketoconazole 1% shampoo, 100 mL
	ketoconazole 2% cream, 30 g
	ketoconazole 2% shampoo, 60 mL

Category	**Drug**
	miconazole 2% solution, 30 mL
	miconazole nitrate 2% cream, 30 g
	miconazole nitrate 2% cream, 70 g
	miconazole nitrate 2% powder, 30 g
	mupirocin 2% cream, 15 g
	mupirocin 2% ointment, 15 g
	mupirocin 2% ointment, 3 g
	mupirocin 2% ointment, 5 g
	silver sulfadiazine 1% cream, 50 g
Wounds	Dressing foam with silver

ATTACHMENT 4 SURVEY LETTER

Subject Title: Invitation to participate in a research study: Podiatrist Prescribing Survey

Dear [name],

It is our pleasure to invite you to take part in a research study evaluating the financial implications for the Australian Government and patients if prescriptions from prescribing podiatrists and podiatric surgeons were eligible for subsidy under the Pharmaceutical Benefits Scheme (PBS).

This study titled '*Budget Impact Assessment of Pharmaceutical Benefits Scheme Subsidies for Clients of Endorsed Podiatrists and Podiatric Surgeons'*, is led by the Centre for Applied Health Economics Griffith University and is endorsed by the Allied Health Professions Office Queensland.

Information from this study will help to inform policy makers about the impacts of recognising endorsed podiatrists and podiatric surgeons as eligible prescribers for the PBS, potentially improving patient access to care.

You have been invited to participate in this important study because you are a practising podiatrist/ podiatric surgeon within Australia.

What we will ask you to do

- Complete a short 5-10 minute online survey. The survey will ask you questions about your prescribing habits over the last 12 months. All information that you provide will remain anonymous and confidential.

If you are interested in participating, please go to this link: XXXXXXX

For further information about the study, please refer to the attached Participant Information Sheet or contact Josh Byrnes: j.byrnes@griffith.edu.au, or Sundeep (Sunny) Pathak s.pathak@griffith.edu.au.

Thank you in advance for your consideration.