

January 2026

Queensland Health proposed Medicines and Poisons (Medicines) Regulation 2026

AMA Queensland thanks Queensland Health for the opportunity to comment on its consultation paper regarding changes to the Medicines and Poisons (Medicines) Regulation 2021. Please see below feedback from members of our Committee of General Practice.

Doctor #1

- A requirement for immunisers to upload the immunisation to the Australian Immunisation Register should be embedded. I have noted a consistent lack of uploading to AIR by Queensland Health facilities, particularly for women who are post-partum. Practicing “to the full extent of their professional qualifications and training” must extend to adequate documentation and clinical handover by recording an immunisation in the AIR and since it is not happening consistently now, it needs to be mandated. To not mandate this fragments care and risks patient safety.
- Paracetamol: it would be prudent to specify that the dose of paracetamol is 15mg/kg and that paracetamol is dosed by weight, not age. For example, while a box of paracetamol may state that the dose for a 12 year old or older is 1g, it is not appropriate to give a 40kg 12 year old 1g as that person’s dose is 600mg.
- In the primary care setting, where the vast majority of vaccinations are given, it is common practice for immunisations to be checked by 2 clinically trained immunisers – eg the GP and the practice RN. It would be prudent for these amendments for immunisation when carried out by non-doctors that 2 immunisers (as defined in the regulation) must check and confirm each immunisation. As a matter of patient safety.
- It is completely inappropriate to suggest that age restrictions be removed for pharmacy immunisation.
 - Immunisation of infants may appear a simple process but in fact is a complex consultation heavily reliant on parent trust. It requires knowledge of surface anatomy and communication and examination skills which pharmacists are not trained in. New parents respond poorly to any hesitation or lack of confidence in handling of the infant, set up, and reassurance and education at time of vaccination.
 - Incorrect immunisation of infants or a suboptimal experience at time of immunisation greatly affects parent trust and buy-in with the National Immunisation Program, and this would detract from the intent behind these regulations in addressing immunisation decline in Qld.
 - Immunisation of infants occurs during child health checks, including developmental milestones and opportunistic intervention eg parental symptoms of post natal depression/anxiety. Pharmacists are not trained to leverage this preventative health

opportunity. Encouraging immunisation of infants by pharmacists fragments care and risks the longitudinal doctor patient relationship.

- It is appropriate to remove barriers to administration of adrenaline for anaphylaxis. Benefits far outweigh risks for removing as many barriers as feasible for the prompt administration of adrenaline.
- Anecdotally, there are many reports of midwife ambivalence towards the National Immunisation Program schedule, including the hepatitis B vaccination at birth, which we have seen in the United States is one of the first vaccinations targeted by the anti-vaxxer movement. I would be interested to see how the immunisation education for midwives addresses the science of immunisation and how vaccines are chosen for the National Immunisation Program, to correct what appear to be some misconceptions common to this craft group.

Doctor #2

- Totally agree with [Doctor #1] on all points.
- In particular, the link between immunisation and child health checks will be lost and this can only lead to missed opportunities to pick up issues with the child or the parent. This model is a far cry from the one where immunisations and health checks were done at the local community maternal and child clinics by trained nurses. When these were all shut down, GPs filled the gap and have provided continuity of care from the neonatal check at 1 week all the way to the 4 year old preschool check and immunisations. Many of us would be well aware of how these interactions provided multiple opportunities for parents to seek information, reassurance and/or treatment.

Doctor #3

- I agree with [Doctors #1 and #2]. A vaccine is not just a vaccine. It's an opportunity to assess development in the child and also the parents' wellness. We often pick up language delays and post natal depression at these appointments. Family violence is the other important issue that is picked up.
- At a time when vaccine hesitancy is at an all time high it makes no sense to send patients away from their trusted general practice. Their GP who knows them.
- I have also had many patients be discharged from a particular hospital without having the recommended vaccines. More so than any other hospital. I have heard from a drug rep that the nurses at that hospital are not keen on certain vaccines.

Doctor #4

- Thanks all - I'd previously submitted concerns about the lack of clinical governance/guardrails in the proposal, particularly because "any S4 immunisation" is broad and likely captures scenarios well outside typical provider training and routine practice (e.g. travel vaccines requiring detailed itinerary assessment, complex comorbidities, and vulnerable groups such as immunocompromised patients).

- Queensland Health's response was essentially that practitioners should "know their limits" and self-assess readiness. That's a weak governance position for a system-level expansion of scope and creates a real risk of out-of-scope practice.
- Question is how will this be monitored and what is the escalation/management pathway if out-of-scope vaccinations occur or adverse outcomes arise? A guidance document doesn't address accountability or oversight.
- One practical alternative suggested by a colleague: limit the scope to QHIPS/NIP (or otherwise clearly defined program vaccines) rather than "any S4 immunisation medicine." That seems a sensible way to improve access without opening up higher-risk travel/complex vaccination by default.

Doctor #5

- Yes agree with [Doctor #3] strongly and firmly.
- Vaccination involves checks and consultations around it on related and relevant matters and health issues including feeding, bowel, bladder, and any symptomatic issues such as Reflux, constipation, Diarrhoea and other GIT symptoms and also general systemic examination
- And YES... "Immunisation of infants is not a simple process of just injecting vaccines, but in fact is a complex consultation heavily reliant on parent trust and also friendly and safe environment for the infant and children, and plays an important role in preventing and spreading communicable diseases, discussion on Vaccine objecting parents to educate them on the utmost significance of vaccinations and related to very rare side effects and long term benefits
- A requirement for immunisers to upload the immunisation to the Australian Immunisation Register should be embedded -- This is very important and not to be missed, R/N usually help with this
- I totally 100 % agree with [Doctor #1's] points cited below: "it would be prudent to specify that the dose of paracetamol is 15mg/kg and that paracetamol is dosed by weight, not age".

Doctor #6

[Please note Doctor #6 advised they have also personally provided the below feedback to Queensland Health]

- The intent to improve access to timely immunisation services is supported, particularly by reducing unnecessary restrictions and enabling delivery in a broader range of community settings. Embedding authorisations in the Regulation (rather than relying on profession-specific instruments that require frequent updating) may also improve consistency and responsiveness as new vaccines become available.
- At the same time, the proposed wording appears broad (e.g., "any S4 immunisation medicine without a prescription") and may create unintended scope expansion into more complex immunisation contexts (notably travel medicine), as well as uncertainty about how higher-complexity vaccines will be managed safely in the future.
- **Key concerns framed as considerations/questions**
 - **1) Potential unintended expansion into travel medicine**

- **Consideration:**
If the authorisation applies to “any S4 immunisation medicine,” does this explicitly include travel vaccines?

Travel vaccination is often clinically complex and requires careful assessment of itinerary details, timing, contraindications, comorbidities, medication interactions, and documentation requirements. There is a risk that travel vaccines could be administered in a “transactional” manner (e.g., based on general online guidance) without adequate patient-specific assessment.
- **Question for clarification:**
What guardrails are intended to ensure that higher-complexity immunisation decisions (such as travel vaccination) are consistently managed within appropriate competence and governance frameworks?
- **2) Yellow fever**
 - **Consideration:**
Yellow fever vaccination commonly sits within additional authorisation, documentation, and quality requirements beyond routine vaccination practice.
 - **Question for clarification:**
How will the framework explicitly address vaccines like yellow fever to avoid ambiguity or inconsistent interpretation of whether they are included under “any S4 immunisation medicine”?
- **3) Future vaccines and “future-proofing” vs complexity**
 - **Consideration:**
A key driver appears to be “future-proofing” by avoiding the need for repeated updates as new immunisation medicines become available. While this improves agility, it may also unintentionally capture future vaccines that require heightened safeguards (e.g., specific contraindication screening, enhanced consent processes, restricted settings, accreditation requirements, or additional documentation/observation standards).
 - **Question for clarification:**
What mechanism is intended to manage future “high-complexity” immunisation medicines that may warrant additional conditions, exclusions, or credentialing beyond standard immunisation training?
- **4) Midwife scope – rationale and potential unintended broadening**
 - **Consideration:**
Midwives are already able to administer relevant antenatal and pregnancy-related vaccines under existing arrangements. The principal benefit of a broader Regulation-based authorisation appears to be administrative simplicity (avoiding updates when new relevant vaccines become available).
 - **Question for clarification:**
What is the policy rationale for expanding midwife authority to “any S4 immunisation medicine” (if that is the intent), rather than a pregnancy/postpartum-focused scope

aligned to typical midwifery practice - particularly if broader wording could unintentionally include vaccines outside maternity care (e.g., travel vaccines)?

- Overall, the direction of improving access and reducing unnecessary restrictions is supported. However, the breadth of the proposed authorisation raises important questions about boundaries and safeguards for complex vaccine decision-making (especially travel medicine or for high risk, complex patients), the handling of special-category vaccines such as yellow fever, and the governance approach for future S4 immunisation medicines that may require additional controls. Clear clarification on these points would help minimise unintended consequences while preserving the benefits of improved access and regulatory agility.