Full Submission Aesthetic Beauty Industry Council (ABIC) Submission on Nurse-Led Cosmetic Clinic Reforms in Queensland

Executive Summary

This submission urgently calls on Queensland Health and the Queensland Government to implement immediate regulatory reforms to enable nurse-led cosmetic clinics to lawfully possess and administer Schedule 4 (S4) medications (such as botulinum toxin and dermal fillers) under appropriate oversight. The Aesthetic Beauty Industry Council (ABIC), as the peak body representing over 25,000 Australian aesthetics practitioners, presents a comprehensive, evidence-based case that current restrictions in Queensland are misaligned with national best practice and are producing significant unintended consequences for public safety, healthcare access, economic activity, and workforce equity.

We propose a balanced path forward – including the introduction of an Extended Practice Authority (EPA) and/or a Queensland-specific poisons permit model for cosmetic S4 medicines – that upholds patient safety while preserving the viability of nurse-led clinics. This approach has been successful in other jurisdictions (notably Victoria's poisons permit system) and would bring Queensland into regulatory consistency with the rest of Australia.

Key Issues: Recent enforcement interpretations of the *Medicines and Poisons Act 2019 (Qld)* and associated regulations have effectively made it illegal for registered nurses (RNs) in cosmetic clinics to purchase or hold stock of S4 injectables, even when operating under established prescribing arrangements. This abrupt change, issued via a Queensland Health fact sheet in late 2024 without consultation or transition period, has **jeopardized hundreds of nurse-led small businesses** and disrupted services for thousands of clients.

While ABIC fully supports the Government's intent to ensure safe use of medicines, the current blanket restriction on RNs is disproportionate to actual risk data and has led to severe collateral impacts:

- **Patient Safety Risks:** Counterintuitively, overly rigid rules are pushing some consumers to seek treatment from unregulated or underground providers or interstate clinics, increasing public health risks – the very outcome the policy seeks to avoid. In regulated settings, adverse events are exceedingly rare (~0.01% incidence) and comparable between doctor-led and nurse-led treatments.

- **Access and Equity:** Nurse-led clinics, particularly in regional and suburban Queensland, have historically provided safe, affordable cosmetic healthcare locally. Forcing these clinics to close or dramatically raise prices (to cover on-site prescribers or per-patient dispensing) will reduce access, especially for rural and middle-income clients, leading to higher costs and wait times for Queenslanders file.

- **Workforce and Economic Impact:** An estimated 800–900 cosmetic RNs in Queensland (95% of whom are women) are affected. Many are highly experienced clinicians and small business owners who have invested years in building their practices. The cosmetic injectables sector contributes approximately $800 million–$1 billion annually to Queensland's economy, with nurse injectors driving roughly half of this value. Current restrictions put this economic contribution, and the jobs of support staff and apprentices, at serious. Already, distress and financial hardship are widespread – ABIC has been inundated with reports of nurses facing clinic closure, bankruptcy, or career termination in the wake of the new enforcement stance.

- **Regulatory Inconsistency:** Queensland's policy is now an outlier. Other Australian states and territories have more flexible frameworks that recognise the competencies of RNs in this field. For example, Victoria's poisons permit model allows experienced RNs or clinics to obtain permits to purchase and hold S4 cosmetic medicines under defined conditions, in collaboration with prescribers, with no evidence of compromise to public safety. Internationally, comparable jurisdictions (Canada,

New Zealand, many U.S. states, Ireland) likewise permit nurse injectors to hold stock and practice under medical oversight. Aligning with these best practices would support workforce mobility and national consistency while maintaining rigorous standards.

- **Professional Collaboration and Autonomy:** Modern multidisciplinary care relies on effective collaboration between doctors and nurses. Under previous models, doctors and nurse practitioners (NPs) provided oversight via telehealth consultations and prescriptions, enabling RNs to treat patients safely and efficiently. The new rules eliminate this collaborative flexibility by requiring a prescriber's constant on-site presence, which is often logistically and economically infeasible. Prescribing doctors themselves have raised concerns that the changes limit their ability to supervise remotely and reduce service capacity across the sector. In a healthcare system facing workforce shortages, constraining RNs from practicing to their full competency is not an efficient use of skills and places undue pressure on doctors.

Proposed Solution: ABIC urges the Queensland Government to implement an immediate regulatory reform through an Extended Practice Authority for RNs (Cosmetic S4 Injectables) or a similar instrument, to allow accredited cosmetic RNs to lawfully purchase, possess, and administer S4 medications in clinical settings, under appropriate oversight and conditions. This EPA, established by the Chief Executive of Queensland Health under section 232 of the Act, would essentially carve out a legal pathway for nurse-led clinics to continue operating safely. Simultaneously, we recommend pursuing legislative amendments to embed a permanent permit or endorsement scheme (mirroring Victoria's model) in Queensland's medicines and poisons regulatory framework. By enacting these reforms, alongside robust safeguards like mandatory protocols, reporting requirements, and ongoing training, Queensland can both protect public safety and empower its healthcare workforce.

This submission provides a detailed rationale for these recommendations, drawing on legal analysis, clinical safety data, economic modelling, and real case studies of Queensland nurses and patients impacted by the status quo. The evidence overwhelmingly demonstrates that the proposed path is urgent, feasible, and firmly in the public interest.

ABIC stands ready to collaborate on the design and implementation of the new framework, and we urge policymakers to treat this issue as a high priority. By restoring a sensible regulatory balance, Queensland can avoid further harm, support a predominantly female-led industry, and ensure its citizens continue to have access to safe cosmetic medical services. The following sections outline the background of the issue, the detailed impacts observed, comparative approaches, and our specific recommendations for reform.

Background and Context

Queensland's Current Restrictions on Cosmetic S4 Injectables

In Queensland, Schedule 4 medicines (prescription-only medications) are governed by the *Medicines and Poisons Act 2019* (MPA) and the *Medicines and Poisons (Medicines) Regulation 2021* (MPMR). These laws set out who may prescribe, buy, possess, and administer such medications. Historically, many cosmetic injectable clinics in Queensland have been nurse-led, that is, operated by a registered nurse injector who provides treatments such as anti-wrinkle injections and dermal fillers. Under the previous prevailing practice, these nurse-led clinics functioned via collaborative arrangements with medical prescribers:

- A doctor or (authorised prescribers) would consult with each patient (often via telehealth) and issue a prescription for the S4 injectable if appropriate.
- The prescribed medication would be lawfully obtained (commonly ordered through a wholesaler by the prescriber) and consigned to the nurse's clinic for administration.
- The RN would then administer the treatment to the patient under the prescriber's authorisation and oversight (though the prescriber was not physically on-site, they were available as needed and often oversaw protocols, follow-ups, and adverse event plans).

This model was designed to comply with the letter and spirit of the law, the prescriber was always involved in the decision-making and prescription process, and RNs did not act independently or outside their scope. Importantly, this collaboration allowed services to be delivered efficiently across Queensland, including in regional areas where on-site cosmetic doctors are scarce. It provided a means for qualified nurses to utilise their specialised training in cosmetic medicine, while patients benefited from the convenience and generally lower cost structure of nurse-led clinics, without any compromise in safety outcomes (as discussed later in this submission).

In late 2024, however, Queensland Health issued a new interpretive guidance (fact sheet) that upended this model. The fact sheet explicitly stated that under Queensland law:

- Only doctors or NPs may purchase or order S4 cosmetic injectables to hold as stock, and only if they are physically present at the clinic to have exclusive custody and control of the medicines.
- Registered nurses (and any person who is not an authorised prescriber) cannot lawfully buy, possess, or store S4 cosmetic injectable stock in a clinic for general use. RNs may only possess an S4 medicine that has been dispensed for a specific patient (e.g. via a pharmacy on a per-prescription basis) and even then must not allow it to be accessible to others.
- Standing orders or standing drug protocols cannot be used to circumvent the need for a patient-specific prescription in cosmetic injectable procedure, and telehealth prescribing remains legal but does not change the prohibition on RNs holding stock. In practice this means even if a telehealth consultation is done, the medication must be dispensed per patient (or a doctor on-site must hold it).

Although the legislation itself did not change, Queensland Health's clarified interpretation and enforcement stance had an immediate effect on nurse-led clinics. What had been common practice under a reading of the law that allowed collaborative stock management was now deemed non-compliant essentially overnight, despite previous guidance to the contrary directly provided to Nurse-led clinics by Queensland Heath over a number of years. Nurse clinic owners who has been previously advised that they were complaint by Queensland Health, suddenly faced the reality that they could no longer order or stock commonly used products like Botox® or dermal fillers for their patients unless they brought in a doctor or NP to effectively take over as the stock holder on premises. This interpretation cast doubt on the legality of the guidance issued by Queensland Health to Nurse-led clinics and their longstanding arrangements where a doctor was off-site but providing prescriptions. The fact sheet implied such models amounted to an unauthorised supply chain if the prescriber was not physically present to control the drug stock.

Lack of Transition and Consultation

Critically, this enforcement change was introduced without industry consultation or any phased transition period. The updated fact sheet was released in December 2024 with immediate effect. Nurse-led businesses that had been operating in good faith, under what they (and many legal experts) were led to believe by Queenland Health was a lawful framework, were given no advance notice or time to adjust their business models. As a result, widespread confusion and distress ensued across the industry. Many clinicians learned of the change abruptly via the Queensland Health website or second-hand from professional networks, causing shock and panic about potential non-compliance. This abrupt approach has been noted by ABIC and others as a serious concern in itself, even where regulatory clarity was needed, a more measured rollout (with input from stakeholders and a grace period for compliance) would have mitigated the immediate harm now being experienced.

ABIC acknowledges that Queensland Health's goal was to ensure alignment with the law and prevent any unsafe or unlawful handling of prescription drugs. We share the commitment to patient safety and regulatory compliance. However, we must underscore that the manner and absolutism of this policy implementation have

led to severe unintended consequences. The interpretation effectively treats all nurse-led clinics the same as potentially "unlawful" actors, despite many having scrupulous records and working under medical supervision.

The policy did not differentiate between, for example, an experienced RN running a fully compliant clinic versus someone operating outside the margins, instead, a broad brush approach shut down the standard operating procedure for an entire sector.

Scale of Impact on the Industry

Queensland's aesthetic medicine sector is substantial and has grown rapidly over the past decade. The cosmetic injectables domain (primarily anti-wrinkle toxin and dermal filler treatments) forms a large part of this industry. Internal ABIC data collated from various sources provides an estimate of the Queensland cosmetic injectables landscape:

- **Registered nurses specialising in cosmetic injecting (QLD):** Approximately 800 to 900, of whom about 95% are female. These include many senior RNs with advanced training and years of cosmetic injecting experience.
- **Cosmetic doctors practicing injectables (QLD)**: Estimated **200 to 300** (many of whom serve as prescribing partners or medical directors rather than full-time injectors).
- **Nurse-led cosmetic clinics**: Hundreds across the state (Queensland has about **567 licensed cosmetic injectable business premises** in total, the majority believed to be nurse-owned or nurse-operated).
- **Annual cosmetic injectable procedures in QLD**: Roughly 400,000 to 800,000 treatments per year are performed in Queensland, out of ~5 million nationally. This indicates Queensland represents a significant share (10–16%) of Australia's cosmetic treatment volume.
- **Economic value**: Australia's cosmetic injectables market is valued at around $4.1 billion AUD per annum, of which Queensland's share is about $800 million to $1 billion. Of that, an estimated $500–600 million in annual revenue is generated by nurse-led services in Queensland. This includes not only the nurses' fees but also the cascade of economic activity (clinic rentals, product purchases, support staff employment, etc.).

These figures illustrate that the recent regulatory interpretation is impacting a large workforce and a major healthcare service sector. The majority of those directly affected are registered nurses, predominantly women, who have been exercising advanced skills in a field where they have demonstrated competence and safety. Many have built small businesses/clinics which also employ other staff (administrative personnel, dermal therapists, trainees, etc.). The ripple effect of destabilising this sector is enormous: it threatens the livelihood of practitioners, the continuity of patient care, and the ancillary jobs tied to these clinics.

National and International Comparison

It is important to note that Queensland's restrictive stance is not mirrored elsewhere in Australia. In most other states:

- There is recognition of nurse injectors' role in cosmetic medicine. No other state has interpreted their drugs and poisons laws as forbidding nurses from holding stock under a doctor's prescription to the extent Queensland now has. For instance, Victoria has taken a collaborative approach: experienced RNs can either operate under a supervising doctor's standing order (for each patient) or obtain a specific permit/license that enables them to purchase and hold S4 cosmetic medicines in their practice, subject to strict conditions and oversight. This Victorian "poisons permit" model is often cited as best practice, balancing autonomy with accountability.
- Other states like **New South Wales** and **Western Australia** have not issued any similar crackdown; in NSW, many nurse-led clinics continue operating under doctor remote oversight without incident

(indeed, some Queensland patients and nurses are now looking to NSW as an attractive environment, which raises cross-border inconsistency issues.

- At the national regulatory level, the Nursing and Midwifery Board of Australia (NMBA) and the Medical Board (via AHPRA) have focused on ensuring proper training and informed consent in cosmetic practice, but they have not prohibited nurses from administering cosmetic injectables. The NMBA's position statement on cosmetic procedures emphasises that a prescription and a consultation with a prescriber is required prior to a nurse administering S4 cosmetic injectables, a requirement nurse-led clinics in Queensland were already adhering to under the prior mode. In other words, the national professional standards assume nurses can administer such treatments so long as a qualified prescriber has assessed the patient. Queensland's new interpretation goes a step further by preventing nurses from even holding the medication in anticipation of administering it.

- Internationally, many jurisdictions allow nurse practitioners or specially certified nurses to prescribe or at least dispense cosmetic injectables, and even where RNs are not independent prescribers, they often can administer under physician oversight without the physician physically present. ABIC's review of global practices found that countries like Canada, New Zealand, the UK/Ireland, and numerous U.S. states have well-established frameworks where nurse cosmetic injectors operate safely. For example, Canada and New Zealand allow RNs to hold stock of injectables via medical directives or standing orders, and the United States (in states such as California, Texas, etc.) permits RN administration of injectables with varying levels of supervision. Globally, the trend is towards empowering nurses (with appropriate qualifications) to deliver these services, given the strong safety record, rather than restricting them.

In light of these comparisons, Queensland's position appears anomalously stringent. It has created a patchwork in which a nurse injector considered fully competent and legal in Melbourne or Sydney is suddenly deemed incapable of safely holding medication stock in Brisbane. This inconsistency undermines efforts at a cohesive national healthcare framework and hampers workforce mobility, as nurses may choose to leave Queensland or cease practice due to the regulatory environment. It also means Queensland patients may travel interstate for services, raising questions about the equitable availability of services within our state.

About ABIC and Our Commitment

The Aesthetic Beauty Industry Council (ABIC) is the peak industry body for the aesthetics and beauty sector in Australia. We represent practitioners across the spectrum, including cosmetic nurses, cosmetic physicians, dermal clinicians, beauty therapists, educators, and clinic owners. ABIC's mission is to elevate standards, support professional development, and advocate for safe and ethical practice in the industry.

ABIC has been at the forefront of responding to the issues arising from Queensland's S4 cosmetic injectable restrictions. We have:

- Collected data, case studies, and member feedback to understand the real-world impacts (some of which are presented in this submission).

- Engaged with legal experts and regulatory consultants to explore compliant solutions that could both satisfy legislative requirements and allow the industry to continue serving the public.

- Expressed a strong desire to work *collaboratively* with Queensland Health and other authorities to resolve these challenges. We respect the role of government in protecting public safety and do not seek to diminish regulatory controls, but rather to modernise them in light of evidence and practical experience.

ABIC is heartened to see that Queensland Health, in its April 2025 revised fact sheet, indicated an openness to engaging with industry and a commitment to help clinics achieve compliance. We take this as a positive signal. This submission, therefore, is offered in the spirit of constructive collaboration. We aim to present solutions

that meet the government's safety objectives while averting the serious negative outcomes currently unfolding.

In the following sections, we detail the specific issues caused by the present restrictions, present evidence and case studies, and then outline our recommended path to reform, including the introduction of an Extended Practice Authority and legislative amendments.

Impacts and Issues Analysis

Public Safety and Clinical Evidence

Safety Record of Nurse-Led Practice: Patient safety is, and must remain, the paramount consideration in any discussion of S4 cosmetic injectables. Fortunately, the evidence indicates that cosmetic injectable treatments have an excellent safety profile in Australia, regardless of whether they are administered by a doctor or a nurse under supervision. Adverse events are exceedingly rare relative to the volume of procedures performed:

- Nationwide, on the order of 3–5 million injectable procedures (using products like botulinum toxin and dermal fillers) are performed each year, yet the adverse event rate is estimated around 0.01% (0.009–0.016%). This is roughly 1 in 10,000 procedures resulting in an adverse event requiring reporting, an exceptionally low incidence. In fact, Australia boasts one of the lowest reported adverse event rates globally for these procedures.
- In Queensland specifically, using high-end estimates, ~800,000 cosmetic injectable treatments might be done per year for 67 formal complaints or reported incidents – an incident rate of about 0.008%. Even under a lower volume assumption (~400,000 treatments), the rate is still only ~0.017%. These figures underscore that serious complications are very uncommon.
- The types of adverse outcomes that are most concerning (e.g., vascular occlusion leading to tissue necrosis or blindness, anaphylactic reactions, strokes) are extremely rare but known risks of the procedure in general. Minor side effects (bruising, swelling, temporary asymmetry, ptosis/drooping) occur at higher rates but are usually self-limiting and not dangerous.

It is crucial to emphasise that there is no data to suggest that RN-led clinics have worse safety outcomes than doctor-led clinics. To our knowledge, neither the Therapeutic Goods Administration (TGA) nor the Australian Health Practitioner Regulation Agency (AHPRA) separates adverse event statistics by the profession of the injector, precisely because both doctors and nurses adhere to the same prescribing and practice standard. Insurers and industry reports similarly indicate that the overwhelming majority of complications are minor and can be effectively managed by trained practitioners of either background. Moreover, both doctors and nurses who practice cosmetic injecting undergo similar training in managing these rare events (for example, both learn to use hyaluronidase to address filler-related vascular occlusions, both train in basic life support for allergic reactions, etc.).

No Evident Safety Justification for the Clamp-Down: Given the above, the recent move to bar nurses from holding or administering S4 injectables unless a doctor is on-site appears not grounded in an evidence-based safety need. If nurse-administered treatments had shown a disproportionate rate of complications or if there were systemic safety problems traced to the nurse-led model, ABIC would support tighter controls. However, that simply is not the case. On the contrary, many nurse injectors have impeccable track records. For instance, one experienced RN from Queensland reported "I have never had a single incident in 7 years of injecting" under telehealth prescribing oversight. This is not an unusual testimonial, the professional standard among properly trained cosmetic nurses is very high. Queensland Health's own statements acknowledge that the law change was about legal authority, not a sudden spike in patient harm events.

It is telling that the fact sheet update came after a legal review rather than because of any public health crisis. In fact, a 2017 incident in Sydney (where a young woman tragically died after a cosmetic procedure performed by an inadequately qualified individual) underscores that risks arise when unqualified or unscrupulous providers operate – not when properly credentialed nurses practice under supervision. The lesson is to bring practitioners under the regulatory tent with appropriate controls, rather than driving practices out of the mainstream.

Unintended Safety Risks of Over-Regulation: Ironically, if the current restrictions remain, Queensland could see heightened safety risks through several mechanisms:

- **Black-market treatments:** When access to legitimate cosmetic services becomes too difficult, some consumers will be tempted by the black market – e.g. obtaining Botox or filler at cut-rate prices from unlicensed providers or via DIY import kits. Already, we are aware of increasing social media activity by unqualified individuals advertising cosmetic injections outside the regulatory framework. Such black-market operations lack any oversight, and patients face dramatically higher risks (unsterile product, lack of complication management, etc.). A rigid regulatory environment that pushes demand underground can paradoxically *increase* the very harms the regulation aims to prevent.
- **Medical tourism or interstate travel:** Patients with the means might travel to NSW or other states (or overseas) to get treatments more conveniently. This poses issues: interstate, they are outside the care continuum of their local providers; overseas, standards vary widely and follow-up for complications becomes very difficult. We have begun hearing reports of Queensland clients considering flights to Sydney for a day of cosmetic treatment because their trusted local nurse injector can no longer accommodate them without onerous new costs. This displacement is neither desirable for continuity of care nor for Queensland's economy.
- **Clinics operating in the shadows:** Some nurse-led clinics, desperate to keep serving their patients, might be tempted to find workarounds that are not strictly legal (for example, using interstate prescribers to ship patient-dispensed vials which are then informally pooled). While ABIC advocates full compliance, the reality is that if regulatory settings are seen as unreasonable, compliance suffers. It is far better to have a workable legal framework that brings everyone into compliance than one that incentivises evasion.

In summary, the current blanket prohibition is not necessary from a pure safety standpoint. A more nuanced approach – which we propose – would continue to safeguard patients through training, protocols, and oversight, without depriving the public of safe services or encouraging illicit alternatives.

Patient Access and Equity

Reduced Access to Services: Queenslanders have enjoyed broad access to cosmetic injectable services through a mix of provider models. Nurse-led clinics, in particular, have expanded services into communities that previously might not have had local options. For example, small towns or outer suburbs often do not have a resident cosmetic physician, but a local RN with cosmetic training can operate a clinic that serves that community's needs (with a remote doctor providing scripts). This model has democratised access to cosmetic procedures, making them more affordable and geographically accessible. Now, with nurse-led clinics in peril, many patients face the prospect of losing their convenient local service:

- If a nurse clinic closes, patients may have to travel far to find a doctor-led clinic (if one exists in their region). For those in regional areas, this could mean hundreds of kilometres of travel or simply going without the service.

- Remaining providers (mostly doctors) will likely be concentrated in urban centers, potentially leading to longer wait times and higher fees due to increased demand and reduced competition.
- Certain populations, such as working parents or those with limited mobility, will find it much harder to access care if the local nurse injector who accommodated their schedule is gone.

Cost Implications for Consumers: One of the supported models under the new requirements effectively forces a doctor's physical presence and involvement in every treatment session, which drives up costs significantly.

Doctors and NPs command high hourly rates (one nurse cited quotes of $400/hour for a supervising doctor just to oversee the medicine cupboard without performing injections. For a small clinic, these costs must be passed on to the client or absorbed, neither of which is sustainable. As a result:

- Many clinics have already or will soon implement price increases for treatments, to cover the additional cost of compliance (per-patient pharmacy dispensing fees, on-site prescriber salaries, etc.). One nurse estimates at least 30% of her clients will not be able to afford the rising costs or cope with new delays in treatment under the enforced model. These are often clients on moderate incomes who treated themselves occasionally, they will be priced out of the market.
- Price hikes could make cosmetic treatments a luxury only accessible to higher-income individuals, undoing years of progress in accessibility. This raises equity concerns, as personal appearance services like cosmetic injectables, while elective, have tangible benefits for individuals' self-esteem, professional confidence, and even mental health. We have accounts of clients who use these treatments to maintain a confident appearance in customer-facing jobs or to avoid age-related workplace discrimination; making these services inaccessible to all but the wealthy has social consequences.
- Additionally, if clinics must rely on pharmacy dispensing for every single treatment, patients might face delays or logistical hurdles in getting their treatment. Under a stock model, a nurse could treat a walk-in or a last-minute appointment as long as a prescriber authorised it; now, if each vial must be pre-ordered per patient, any scheduling change can lead to treatment delays or medicine wastage (if a patient no-shows after their vial was ordered, for example). All this introduces friction that ultimately inconveniences the client.

Impacts on Specific Groups: The curtailment of nurse-led cosmetic services may disproportionately affect:

- **Regional and rural clients:** as noted, these areas often rely on nurse providers. If those providers shut down, rural clients either forego treatment or incur travel/time costs to go elsewhere.
- **Female clients:** The majority of cosmetic injectable consumers are women. Many are seeking a confidence boost or maintenance of appearance for personal or professional reasons. We mention this to highlight that the impact on women is twofold, as providers and as consumers.
- **Clients who value practitioner continuity:** Many patients have longstanding relationships with their nurse injector, who knows their treatment history and aesthetic preferences intimately. Forcing these patients to transition to a new provider (because their nurse can no longer practice) disrupts that continuity of care and trust. As trivial as cosmetic treatments might seem to some, the rapport and understanding between provider and client is a key part of quality care in this field. It is similar to switching dentists, not dangerous, but certainly not ideal from a client satisfaction standpoint.

Case Illustration – Patient Perspective: One nurse's testimony paints a human picture: she described clients such as teachers on moderate incomes who rely on her clinic's affordable services to maintain their appearance

because it gives them confidence to face workplace challenges (some were targets of age-based bullying like being told they "look tired or old". She worries these clients "won't be able to afford the rising costs or cope with the delays" that the new rules impose. This reflects a broader truth: cosmetic treatments, while elective, play a meaningful role in many ordinary people's lives. We should regulate to ensure safety and ethical practice, but not to erect needless barriers that treat such consumers as if they cannot make personal choices to have safe treatments.

In sum, the public interest is not served by a model that drastically restricts access to an otherwise safe and desired healthcare service. A balanced reform that allows nurse-led clinics to continue will preserve access and choice for Queenslanders, ensuring this segment of healthcare remains equitable and patient-centered.

Economic and Workforce Impacts

The economic fallout of the current restrictions is immediate and profound. As detailed earlier, nurse-led cosmetic services constitute a half-billion dollar industry in Queensland, supporting not only nurses but a network of suppliers and employees. Key economic and workforce considerations include:

Threat to Small Businesses and Jobs: The majority of nurse-led clinics are small businesses or sole traders. Many are owned and operated by women who have poured personal savings and years of sweat equity into establishing their clinics. These clinics often employ additional staff:

- **Support staff:** receptionists, practice managers, and administrative personnel who handle bookings, compliance paperwork, and patient coordination.
- **Dermal therapists or beauty therapists:** who might provide complementary services at the clinic (e.g., laser treatments, skin treatments) and rely on cross-referrals.
- **Junior nurses or trainees:** Some larger nurse-led practices serve as training hubs, taking on graduate nurses or students in related fields (two apprentices were employed in one RN's small clinic, now all facing termination if the clinic closes.

When a clinic is forced to shut down, these jobs vanish. Unemployment or underemployment looms for the owners and their staff. Unlike big medical corporations, these small operators often do not have deep capital reserves to weather a months-long service interruption or expensive pivot. ABIC has fielded calls from members who are *considering bankruptcy* or have already given notice to employees because they see no viable way to continue under the new rules. The sudden regulatory change has essentially stranded their investments, costly medical equipment, leases on premises, existing stock of products (which now can't be used unless a prescriber takes custody) all of which becomes sunk cost.

Economic Loss to Queensland: If nurse-led clinics close, a significant portion of the revenue generated will not simply shift to doctor-led clinics; much of it would be lost to the state entirely. This is because:

- Some demand will go unmet (clients who opt out entirely due to increased cost or inconvenience).
- Some demand will shift to interstate providers (as mentioned, near-border clients going to NSW, or even people flying to Sydney/Melbourne for a weekend cosmetic treatment trip). That revenue leaves Queensland's economy.
- Nurse entrepreneurs who might have expanded and hired more staff will halt plans, stunting sector growth. In fact, some are contemplating moving their business interstate where the environment is friendlier, which would be a net loss for Queensland commerce and tax revenue.

In a broader context, the beauty and aesthetic sector is one of the few growth areas of small business dominated by female ownership. Undermining it runs counter to various governmental objectives around

supporting women in business, encouraging STEM and healthcare entrepreneurship, and fostering innovation. As one nurse succinctly put it, the changes have been "a very stressful time dealing with the future direction of the financial stability of the clinic and the job security of my staff. Clinics are being forced to reshape or dissolve not due to market forces or safety failings, but due to regulatory impedimentm something that should give policymakers pause, especially when workable alternatives exist.

Personal Financial and Emotional Toll: We would be remiss not to highlight the individual human toll on practitioners. Many nurse injectors are not high-flying executives; they are working clinicians who might be the primary breadwinners for their families. Some specific case studies collected by ABIC illuminate this:

- One RN, a single mother of two children, has run a successful cosmetic practice for 9 years (and been a nurse for 17 years). She shared that she left an abusive marriage and built her business from scratch to support her family. With the new restrictions, her clinic's revenue has plummeted ("significant reduction in profit") and she faces "uncertainty of ability to cover financial obligations" including her mortgage. The stress has exacerbated her mental health struggles as she contemplates possibly having to "cease offering cosmetic injectables, which is 95% of my service offering, which would mean cease operations". This is a story of immense resilience now met with potential ruin through no fault of her own.

- Another nurse, with 12 years of injecting experience, described being "gut-wrenched that this could all just be snatched from under me" after all her hard work and training. She spoke of not being able to get out of bed for days due to depression over the situation. She and others express a sense of being punished collectively for the misdeeds of a few, despite their personal dedication to safety and compliance.

- A nurse who had recently expanded her clinic to a larger space now finds herself "watching our clinic gradually decline with no clear path ahead". Having taken on loans for expansion, she fears losing everything. She notes that holidays like Christmas and Easter were lost to trying to "navigate these new changes", illustrating the personal sacrifice and stress involved.

These accounts, while anecdotal, are sadly representative of a multitude of similar stories ABIC has documented. The mental health impact on these healthcare professionals is real, anxiety, insomnia, and burnout are increasing. This is particularly tragic given that these nurses have been passionate about their field; they derive satisfaction from making patients happy and confident. Now many feel demonised or unfairly restricted by their own regulators, which is leading some to consider leaving the profession entirely. A few have even consulted lawyers to interpret the legislation, feeling baffled how their long-standing practice model is now labelled "illegal" when legislation itself is broad and had been interpreted differently before.

Gender Equity Considerations: As repeatedly noted, women are at the forefront of this sector. The abrupt restriction predominantly affects women-led enterprises and female employment. At a policy level, this raises questions: Did the impact assessment (if any) consider the gendered impact of effectively shutting down an industry segment largely run by women? In an era where governments espouse support for women's economic empowerment, the handling of this issue appears counterproductive to those goals. Ensuring that skilled female clinicians can practice autonomously (with safeguards) is a matter of professional equity. Many of these nurses have pursued additional qualifications (graduate diplomas in cosmetic nursing, etc.), attended countless trainings, and built patient followings, only to be told that, despite doing everything right, they must now stand down or take on a supervising physician who essentially diminishes their autonomy and earnings.

No other field of nursing in Queensland is subject to such a limitation, even midwives can practice independently in private practice in collaboration with obstetricians, and nurse practitioners have broad prescribing rights. Cosmetic RNs feel singled out and undervalued, despite the evidence of their competence. If Queensland wants to retain this skilled workforce, a change is needed. Otherwise, we may lose these nurses to other states or other industries, which would be a permanent loss of human capital for our health system (notably, some may have been willing to offer their skills to the public system at times, e.g. vaccine drives, if their private practice prospered, but if they exit healthcare entirely, everyone loses).

Opportunity Cost – Wasted Skills and Training: Another economic aspect is the loss of skills. The cosmetic nursing field has drawn many talented clinicians who have invested heavily in training (often at their own expense). Shutting down their practice is a waste of that educational investment. Additionally, Queensland has training institutions and courses dedicated to dermal science and cosmetic nursing, the viability of those programs comes into question if there is no prospect of graduates being allowed to practice fairly in-state. It would be a bitter outcome if Queensland-trained cosmetic nurses feel they must move to Victoria or elsewhere to utilise their training.

In summary, the economic and workforce impacts of maintaining the current restrictive policy are starkly negative: small business closures, loss of employment (especially for women), reduction in state revenue, and the squandering of a skilled workforce. Conversely, implementing the reforms we propose would safeguard these economic contributions and jobs, and would signal that Queensland values both safety *and* the vitality of this health service sector.

Regulatory Consistency and Best Practice Models

Queensland's present framework for cosmetic S4 medicines is an outlier when viewed against other jurisdictions' regulatory approaches. Achieving consistency is important for fairness, mobility, and maintaining Queensland's reputation as a place that embraces best practices in healthcare regulation.

Victoria's Poisons Permit Model – A Case Study:
Victoria provides a useful comparison. Under Victoria's *Drugs, Poisons and Controlled Substances Regulations*, a mechanism exists for clinics or individuals to obtain a *Health Services Permit* (sometimes informally called a "poisons permit") to purchase and store Schedule 4 medicines for use in their practice. In the context of cosmetic injectables:

- A cosmetic clinic in Victoria can apply for a permit that, if granted, authorises the clinic to obtain S4 substances (like botulinum toxin, fillers) directly from wholesalers. The permit application requires demonstrating certain criteria: e.g., that the clinic has appropriate storage (drug safe, temperature control for botulinum toxin), record-keeping systems, a supervising medical practitioner, and standard operating procedures for administration and emergencies.

- Experienced RNs who have a collaborative arrangement with a doctor can effectively run their clinics by operating under such a permit or under explicit written authorisations from a doctor (Regulation 96/97 in Victoria allows nurses to possess S4 meds for a specific patient under a doctor's instruction). The key is that Victorian law does *not* blanket-prohibit nurses from possession; it provides legal avenues for possession when certain conditions are met.

- The Victorian Department of Health also encourages adherence to guidelines and may attach conditions to permits, ensuring that safety protocols are upheld. Importantly, there have been no publicised safety scandals or spikes in adverse events in Victoria attributed to their more permissive model. On the contrary, by having a permit system, authorities in Victoria know which clinics are holding stocks and can regulate them (e.g., via inspections or requiring annual permit renewals), giving greater oversight than a situation where stock is covertly held without authorisation.

Other States:
While specifics vary, other states generally have not interpreted their laws as strictly as Queensland now does. For example:

- **New South Wales (NSW):** Operates under the Poisons and Therapeutic Goods Act. NSW Health has not issued any guidance prohibiting RN possession outright. Many NSW nurse injectors operate with doctors prescribing via telehealth and use patient-specific dispensing. Some larger NSW clinics employ

onsite NPs or doctors, but it is by choice or business model, not by legal necessity (so long as prescriptions are in place).

- **Western Australia (WA):** Has a framework for "Structured Administration and Supply Arrangements" (SASA) where certain medications can be supplied by RNs under protocol in some contexts. While SASA may not explicitly list cosmetic injectables, the spirit in WA has been collaborative; we are not aware of any crackdown on nurse injectors there.
- **South Australia and others:** Similarly, nurse injectors practice with prescriber support. No other state health department has taken the position that a prescriber must physically hold all stock at all times.

The lack of consistent approach across states means that a nurse in Coolangatta (QLD side of the border) is under a completely different regime than a nurse in Tweed Heads (NSW side), despite being part of one contiguous community. This cross-border discrepancy is already causing issues; as one clinic near the NSW border reported, **"we will lose clients to clinics [in NSW] who do not need to raise their prices due to these changes**. Queensland businesses thus face a competitive disadvantage not because of quality or service, but purely regulatory overhead.

National Best Practice Standards:
Nationally, there is increasing attention on the cosmetic industry's regulation (e.g., the recent Ahpra reforms focused on cosmetic surgery). The direction of these reforms has been towards:

- Ensuring practitioners have appropriate credentials and training for the procedures they perform.
- Strengthening informed consent and patient assessment processes (for instance, mandatory psychological screening for cosmetic surgery patients, etc.).
- Improving advertising restrictions and patient protections.

Notably, nowhere in the national discourse has there been a suggestion that RNs should not perform cosmetic injectables. The NMBA's guidelines recognise that RNs can administer cosmetic injectables with a valid prescription in place. The focus is on patient safety via proper process, not on prohibiting one class of professional. The best practice standard is a team-based approach: the nurse, the prescribing doctor/NP, and the clinic all working in concert to ensure the patient's suitability and safety. Queensland's current interpretation undermines that team approach by effectively removing the nurse unless a doctor is physically present.

International Norms:
As mentioned, international practices offer perspective. In countries often held as benchmarks for healthcare quality:

- **Canada:** Nurses (RNs) can administer cosmetic injectables under the authority of a physician's directive. Many provinces allow nurses to not only administer but also, in certain instances, to prescribe or *compounding order* these drugs after additional certification. Canadian regulatory colleges consider this within scope as long as a system of physician oversight exists. The model is quite analogous to what we propose for Queensland, it relies on indirect supervision and written directives, rather than literal on-site monitoring.
- **United Kingdom/Ireland:** Nurses can become qualified as independent nurse prescribers (after obtaining a specific prescribing qualification). In the UK, many cosmetic "nurse prescribers" run their own clinics entirely, only occasionally consulting doctors for complex cases. Ireland requires nurses to get a prescribing license to do this autonomously. These models show that with the right training, nurses are entrusted even with independent prescriptive authority in this field.

- **New Zealand:** Nurses can administer under standing orders or individual prescriptions, similar to the collaborative model we had in Queensland. NZ also has a high safety record and has not moved to ban nurses from holding stock.
- **United States:** The US is patchwork (each state differs), but many states allow RN injectors to function with varying levels of oversight. Notably, even in states known for strict medical practice rules, RNs are not uniformly barred from these roles, instead, rules focus on supervision requirements (some states allow off-site Doctors with phone availability). Crucially, many U.S. medispa businesses thrive under models where a physician oversees multiple nurse injectors across different locations (off-site), highlighting that this can be done safely.

The takeaway is that Queensland's rigid approach is out of step with both national and international regulatory trends. The more common and accepted approach is to regulate how nurses administer (training, protocols, oversight) rather than to preclude them from doing so. By embracing a best-practice model akin to Victoria's or those abroad, Queensland can assure safety and still harness the skills of its nursing workforce.

Support for Change Among Stakeholders:
It's worth noting that within Queensland there is broad support among key stakeholders for a more flexible model:

- **Nurses obviously support change:** not just for self-interest, but because they truly believe in the service they provide and see it as safe and beneficial to patients.
- **Doctors in the cosmetic field**: Many cosmetic physicians have been supportive of their nurse colleagues. They often act as supervisors or business partners. Under the current restriction, they too lose out (they lose collaborations that brought them income and extended their patient base). Doctors are also aware that they cannot meet the entire demand alone. In private discussions, many doctors acknowledge that requiring a doctor consistently in every single clinic is impractical and unnecessary; they would rather use nurses to augment service capacity while they oversee multiple sites or handle complications.
- **Patients**: While patients aren't usually part of legislative consultations, their interests are fundamental. Patient satisfaction and safety outcomes in nurse-led clinics have been excellent historically (these clinics often thrive on word-of-mouth referrals). Many patients have voiced that they care more about the experience and skill of the injector, not their professional title, and that they value having local, affordable options. The letters and messages patients have sent to their nurses as this situation unfolded express disappointment and confusion as to why their trusted provider might have to stop practicing. In essence, the consumer voice would favours more choice and accessibility, as long as safety is maintained.

Therefore, aligning Queensland's regulation with national best practices is not only logically sound but also reflective of what stakeholders want. The Government would face far less pushback and, indeed, earn commendation by pivoting to a solution that other regions have already proven out.

Collaboration, Oversight, and Professional Autonomy

One of the pillars of modern healthcare is enabling professionals to work at the full scope of their practice while maintaining effective oversight and teamwork. The current Queensland approach undermines that principle in the cosmetic injectables context. Here we examine why restoring the ability for RNs to practice with physician collaboration (rather than subordination) is both safe and optimal:

The Collaborative Model – How It Works:
Under a collaborative practice model (which we propose to reinstate and formalise through regulation), **the roles and responsibilities** would be:

- **Medical Practitioner/Nurse Practitioner (Prescriber):** Conducts an appropriate consultation with the patient (either in-person or via telehealth) to assess suitability for treatment. They ensure there are no contraindications, approve the treatment plan, and issue a prescription or order for the medication. They remain available for consultation if the nurse needs advice, and they manage or co-manage any complications beyond the nurse's scope. They might periodically review the clinic's practices or do chart audits to ensure quality.

- **Registered Nurse (Injector):** Performs the actual procedure of injecting the S4 medicine, using their technical skill and aesthetic judgment. The nurse obtains informed consent, educates the patient on the procedure and aftercare, and is the immediate responder to any acute adverse event (e.g., recognising a vascular occlusion and initiating treatment, with a pipeline to call the doctor if needed).

  The RN handles the storage and handling of the medication in the clinic as per legal requirements, maintaining logs and inventory. Importantly, the RN only operates under the authority of the prescription/order given by the prescriber, they do not self-prescribe or treat without that go-ahead.

- **The Clinic/Business Entity:** Ensures all required protocols are in place: for example, a Health Management Protocol (as Queensland's Extended Practice Authorities typically require) covering how the medicines are stored, who has access, how often inventory is checked, emergency procedures, etc. The clinic also ensures that the environment is suitable (infection control measures, appropriate facilities).

This model delineates clear accountability: the doctor/NP is accountable for the prescription (i.e., that the treatment is medically appropriate), and the nurse is accountable for the administration (i.e., that the injection is done safely and correctly). Both share accountability for patient outcomes, which fosters a team approach. Crucially, this setup has been functioning effectively for years in Queensland until the recent halt. It mirrors how many healthcare settings work, consider a surgical theater where a surgeon operates and an anesthetist (doctor) oversees anesthesia, or a general practice where a doctor prescribes a vaccine and a nurse administers it. The law already allows a similar interplay for immunisations, for example, where RNs in Queensland can be authorized under an Extended Practice Authority to administer vaccines without a doctor physically present, provided protocols are met. We are asking for cosmetic medicine to be treated with the same logic.

Why On-Site Supervision is Unnecessary:
The insistence on a prescriber being on-site (with "exclusive custody" of meds) at all times is not only impractical but arguably provides little additional safety benefit:

- Emergencies in cosmetic injections (though rare) such as anaphylaxis or filler embolism require immediate action by the person holding the needle. A doctor in the other room is not significantly faster or more capable in those first crucial minutes than a nurse on her own, the nurse is fully trained to implement emergency protocols. For instance, if an anaphylactic reaction occurs, the nurse will administer adrenaline from the emergency kit. A doctor's presence doesn't change that, except that if things escalate, the nurse would call emergency services just as a doctor would. The presence of a doctor is not a guaranteed safeguard; what matters is that the practitioner on site (nurse) is trained and the protocols are in place.

- If a complication like a vascular occlusion happens, time is tissue, the nurse immediately starts the approved protocol (e.g., injecting hyaluronidase to dissolve filler). A physically present doctor might do the same, or if not experienced, might actually defer to an experienced nurse's knowledge in that realm. Many cosmetic nurses have more hands-on experience with such injectable-specific issues than general practitioners do.

- Telecommunication is ubiquitous. In the uncommon scenario where a nurse needs a prescriber's input during a treatment, they can be contacted by phone or video instantly. The COVID-19 pandemic proved that telehealth can be effectively integrated into care. A doctor could visually assess a patient's condition over video if needed. Thus, indirect supervision can be very effective when protocols and communication channels are clear.

So the marginal benefit of having a doctor sitting in the clinic is small, whereas the cost and inefficiency it introduces are huge. It is far better to utilise doctors in oversight roles across multiple clinics (where they can impact more patients through supporting nurses) than to have them babysitting a single clinic's drug storage.

Efficient Workforce Utilization:
Queensland, like all jurisdictions, has finite healthcare human resources. We face distribution issues (not enough providers in rural areas, etc.) and need to innovate how we deliver services. Empowering nurses to take on extended roles has been a key strategy in many domains: nurse practitioners in primary care, nurse endoscopists, nurse-led clinics for chronic disease management, etc. Cosmetic medicine, though often seen as "elective", is still part of the health ecosystem and benefits from such innovation. If we restrict nurses unnecessarily, we are essentially saying we would prefer a doctor do something a nurse is perfectly capable of, which is an inefficient allocation of skills and training. It also places all burden on doctors, who may then be unavailable for areas where only they can serve.

One can draw a parallel with midwifery: decades ago, obstetricians were required to oversee births even if not necessary, but over time midwives proved they could lead low-risk deliveries, reserving obstetricians for complications or surgeries. The system now is more efficient and arguably just as safe, if not safer (because obstetricians aren't stretched thin doing routine work). Likewise, cosmetic RNs performing routine injectable treatments, with doctors available for oversight or complex cases, is a smart division of labor. If only doctors could inject, either many patients would go untreated or doctors would neglect other duties to perform lip injections, not an optimal use of their advanced training.

Restoring Professional Autonomy and Morale:
Nurses are professionals governed by codes of practice and ethical standards. The current situation, wherein capable RNs feel they are being forced into subservient roles or out of their profession entirely, is damaging to the morale of the nursing workforce. It sends a message (likely unintended) that even if a nurse attains a high level of expertise in a field, the system may still not trust them to practice appropriately. This undermines the notion of a career pathway in cosmetic nursing. If Queensland embraces a reform that acknowledges nurse injectors as legitimate practitioners who can be entrusted with responsibility (under oversight), it validates their professionalism and encourages a culture of accountability and pride. Nurses are far more likely to remain in Queensland, invest in further training, and adhere to regulations if they feel respected by the regulatory framework.

Conversely, an alienated practitioner group might either exit or become disillusioned. None of that is conducive to safety or quality. Regulators generally achieve better outcomes by bringing practitioners to the table (through inclusion and education) rather than by imposing strictures that breed resentment or non-compliance.

Prescriber Perspective:
Finally, let's consider doctors and nurse practitioners in this equation. Under our proposed model, they still play an indispensable role, every patient must be reviewed and the treatment authorised by them. They maintain control over the prescription pad. The difference is they do not need to physically micromanage the stock or the injection procedure if they trust the nurse. Many prescribers find this agreeable. It allows them to extend their practice and collaborate beneficially. Some doctors might prefer a more hands-on approach; they are free to work on-site if they choose, but it should not be mandated by law for every case.

It's also worth noting that nurse practitioners (NPs) themselves are a unique case: NPs are independent prescribers by law. A nurse practitioner specialising in cosmetics can both prescribe and administer. Queensland's law currently still forbids an NP from effectively utilising an RN as an injector under them unless

the NP is also physically present holding the stock (since NPs are treated like doctors in that rule). This is an odd constraint, it means even an NP can't delegate to an RN. If we change the rules to allow RN possession under certain conditions, NPs could run nurse-led teams too, which is another way to increase service capacity. It doesn't make sense that a qualified NP (who might have 20 years of nursing experience and a master's degree) is bound by the same stock restriction; freeing up RNs would also empower NPs to supervise them remotely.

In conclusion, the collaborative, indirect oversight model is a proven safe practice that leverages the strengths of both doctors and nurses. By re-establishing it via an Extended Practice Authority or permit system, Queensland will reaffirm its commitment to multi-disciplinary care, innovation in service delivery, and professional autonomy while still ensuring accountability in the use of S4 medicines.

Proposed Reforms and Recommendations

ABIC respectfully submits a multi-pronged solution to resolve the current crisis. The overarching goal is to create a legal pathway for nurse-led cosmetic clinics to operate safely and in compliance with Queensland law, harmonised with national standards. We detail below both immediate actions and longer-term legislative changes that, together, will achieve this goal. These recommendations are grounded in regulatory mechanisms that are already available or precedented, meaning they are realistic and implementable in the short term.

1. Implement an Extended Practice Authority for Cosmetic S4 Injectables (Immediate Measure)

What is an Extended Practice Authority (EPA)? An EPA is a statutory instrument under the MPA 2019 (Qld) which the Chief Executive of Queensland Health can issue to extend the scope of practice for certain health professionals in defined circumstances. EPAs list what regulated activities a class of practitioners (e.g., registered nurses) may carry out with particular substances, and under what conditions.

Currently, there is an existing EPA titled **"Extended Practice Authority – Registered Nurses"**, which, for example, authorises RNs to give purchase orders for certain medicines and administer under protocol in areas like immunisations, sexual health, etc. However, as the Queensland Health fact sheet notes, **S4 cosmetic injectables are *not* included in the current EPA for RNs**. This is precisely what needs to change.

Proposal: We urge Queensland Health to **create or amend an Extended Practice Authority specifically to include cosmetic S4 medications for nurse injectors**. This EPA could be a new section within the RN EPA, or a standalone EPA (whichever administratively easier), that explicitly allows the following:

- Registered nurses (who meet certain criteria) are authorised to purchase, obtain, possess, and administer specified Schedule 4 cosmetic injectable medicines (e.g., botulinum toxin type A and approved dermal fillers) for the purposes of cosmetic treatments.
- The RN must do so pursuant to a health management protocol and a valid prescription or medication order from a doctor for each administration. (This ensures that diagnosis/prescribing remains with an authorised prescriber; the EPA wouldn't give independent prescribing rights, just the authority to hold, and administer once prescribed).
- The RN must have documented oversight from a named medical practitioner for instance, a collaborating doctor who agrees to provide guidance, be contactable, and regularly review the RN's practice. This could be analogous to how nurse immunisers require a medical mentor in some settings.
- Specific conditions can be enumerated to ensure safety, such as:
    - The RN has completed an accredited training/qualification in cosmetic injecting (for example, a Graduate Diploma in Cosmetic Nursing or a similarly recognised course), or can demonstrate equivalent competency through experience (perhaps a minimum number of years of cosmetic injecting practice, e.g. 2 years full-time).

- The RN's clinic has appropriate Substance Management Plans in place for storage and handling of the S4 substances (e.g., locked refrigeration for botulinum toxin, temperature logs, etc.), and the RN maintains accurate purchase and administration records for audit.
- The RN follows a defined Health Management Protocol (HMP) for cosmetic injectable practice, which would include: patient assessment procedures, consent process, documentation standards, emergency response plan for adverse events, follow-up care guidelines, and periodic review of protocols with the collaborating prescriber.
- The RN must report any serious adverse events to the relevant authority (e.g., to Queensland Health or through a national cosmetical injectable incident registry if one exists) as part of a pharmacovigilance effort. This ensures transparency and ongoing safety monitoring.
- The EPA could initially be limited to specific medicines and uses – e.g., only to TGA-approved cosmetic use of botulinum toxin and hyaluronic acid dermal fillers, to avoid any ambiguity with other S4 substances.

Why an EPA is the right immediate tool: Because an EPA can be established by delegated authority (the Chief Executive's power under the Act) health.qld.gov.au, it does not require an Act of Parliament. It is therefore a

swift solution, an EPA can be drafted and promulgated in a matter of weeks once approved by Queensland Health's internal process. This would provide immediate relief to embattled nurse-led clinics, allowing them to legally resume ordering and holding stock, and thus restoring their business operations while abiding by clear conditions. The EPA mechanism is tried and tested (Queensland uses it for other groups like paramedics, midwives, Indigenous health workers, etc. for various extended roles).

By introducing an EPA for cosmetic RNs, Queensland Health would send a strong signal that it is responsive to the issues and is willing to innovate within existing legal frameworks to address emergent problems. The EPA could even be framed as a pilot or interim measure, for instance, it might be issued with a 2-year sunset clause pending formal legislative review. This ensures that if any adjustments are needed, they can be incorporated when the EPA is renewed or made permanent.

2. Establish a Transitional Licensing/Permit Scheme for Nurse-Led Clinics (Short-Term Legislative Reform)

In tandem with the EPA (or as a fallback if EPA is deemed insufficient), ABIC recommends Queensland create a regulatory licensing scheme akin to Victoria's. This would likely involve amendments to the Medicines and Poisons (Medicines) Regulation 2021, or utilizing existing provisions for approvals/dispensations under the Act, to allow an entity (nurse or clinic) to be granted permission to handle S4 meds.

Proposal: Introduce a new category of licence or approval, for example:

- A "Cosmetic Injectable Possession Permit" available to registered health professionals (or corporate entities with a qualified person) that allows the purchase and possession of specified S4 medicines for cosmetic use at a named premises.
- The permit would be issued by Queensland Health's Medicines Regulation branch (MARU), similar to how other substances or activities are licensed (e.g., some clinics have licences for laser equipment or for schedule 8 drugs storage).
- Criteria for obtaining the permit could include:
  - Nomination of a responsible person (must be a prescribing practitioner or a registered nurse with appropriate credentials) who takes responsibility for the substances.

  - Proof of collaborating prescriber arrangements – e.g., a signed agreement between the RN and a doctor/NP that the latter will oversee prescriptions and be involved in the patient care as needed.
  - An inspection or assessment of the premises for suitable storage and security of medicines (similar to requirements pharmacies or hospitals follow for storing controlled drugs).
  - Payment of a licence fee and agreement to comply with all reporting and audit requirements.
- The permit would explicitly authorise what is currently prohibited: that the permit holder (or authorised nurses under that permit) may **buy and hold stock of the S4 cosmetic injectables** for use in treating their clients, notwithstanding the general restriction in the regulations. It in effect carves out a legal allowance on a case-by-case (permit) basis.

Victoria's model in practice: In Victoria, many nurse-led clinics operate under a Health Services Permit for S4 drugs. This has allowed business as usual with oversight. If Queensland adopted a similar scheme, it could even require that permits be limited to those with, say, a minimum of 2–3 years of experience in cosmetic injecting (to focus on experienced practitioners first). Newer entrants might work under someone else's permit until they qualify. This is similar to how one might tier driving licenses or other privileges.

Benefits of a Permit Scheme: A formal permit regime has multiple benefits:

- **Regulatory oversight:** Queensland Health would know exactly which clinics and individuals are holding stocks. Compliance can be enforced via conditions on the permit, if someone breaches protocols, their permit can be revoked. This targeted oversight is more effective than a blanket ban (which, as discussed, might lead to hidden non-compliance).
- **Flexibility:** Permits can be tailored. For example, Queensland could pilot this scheme by issuing limited permits to start with, assess outcomes after 6-12 months, then expand. It could prioritise regions in need or experienced practitioners. It's a managed way to reintroduce nurse-led stock holding.
- **Public confidence:** The existence of a permit indicates to the public that the clinic is "licensed" by Health, which can inspire trust. It's analogous to having an accreditation. ABIC would gladly help by providing input on standards such permit holders should meet, ensuring they reflect high industry standards.
- **Interim solution on path to legislation:** A permit scheme could be instituted relatively quickly through regulatory amendment (which can often be done by Governor-in-Council without a full Act change). This could act as a bridge until more permanent legislative alignment is done in the Act if necessary.

Extended Practice Authority vs Permit: We mention both EPA and permit because they are not mutually exclusive. An EPA empowers individual RNs across the board (if they meet conditions), whereas a permit is issued to a specific person/entity. Queensland could use an EPA to cover general authority to act, and a permit to cover the specific right to purchase/possess stock. For instance, an RN might need to be named on a permit and also be practicing under the EPA's conditions. This belt-and-suspenders approach might give maximum clarity. However, if one mechanism is preferred, the end result is similar: nurses get legal authority to do what they need to do, under oversight.

ABIC's Impact Report already suggested this idea: "Consideration of a transitional licensing or permit model for experienced RNs in cosmetic practice". We stress "transitional" because we understand the government may

want to treat this carefully, not giving carte blanche forever without evaluation. That's acceptable, our plea is to do something now to stop the bleeding of jobs and services, even if it's labelled an interim trial or provisional scheme. We are confident that the data will show it works well, at which point it can be solidified.

3. Amend the Medicines and Poisons Act/Regulation for Long-Term Clarity (Legislative Alignment)

After immediate fixes are in place (EPA and/or permits), the longer-term solution is to amend the actual law so that the issue doesn't resurface and to future-proof Queensland's regulatory regime. Likely targets for amendment:

- **Medicines and Poisons (Medicines) Regulation 2021 (MPMR):** This regulation lists authorities of various practitioners. An amendment could explicitly add a provision such as: "A registered nurse is authorised to obtain, possess, and administer a Schedule 4 medicine for the purposes of cosmetic treatment of a patient, provided that: (a) the treatment is prescribed or authorised by a doctor, (b) the registered nurse administers the medicine in accordance with any applicable extended practice authority or departmental standard, and (c) any other conditions prescribed by the regulation or the Chief Executive are met." This one clause (worded carefully with legal drafters) would clear the ambiguity that led to the current clamp-down. It would essentially place into law what the EPA/permit tries to achieve administratively.
- **Medicines and Poisons Act 2019 (MPA):** If needed, the Act could be tweaked to create a specific category of "approved person" or a pathway for an approval for non-prescribers in certain settings. The Act already allows for "Substance authority" which covers general approvals, prescribing

  approvals, etc. A new kind of substance authority could be introduced for cosmetic medicine possession by RNs. The benefit of doing it at Act level is permanence and full legitimacy.

The legislative amendments should be crafted in consultation with legal experts, Queensland Health, and stakeholders including ABIC's regulatory committee. ABIC would welcome the opportunity to provide detailed input to legislative drafting to ensure the wording captures the intended permissions and limits.

Our view is that aligning the letter of the law with safe practice will eliminate any uncertainty or reliance on departmental interpretations. It will also prevent future misunderstandings or sudden shifts. Everyone, practitioners, regulators, patients will know exactly what is allowed and under what safeguards.

We note that such legislative change might take some time (several months to a year, depending on parliamentary schedule and priorities). That is why the EPA and permit steps are crucial as immediate measures. However, committing to the legislative change is important for signalling long-term stability. Nurse injectors in Queensland need to know that once this issue is resolved, it won't revert or be yanked away again. Legislative codification provides that assurance.

4. Develop Clear Guidelines and Resources for Compliance

Any new framework should be accompanied by robust guidance to ensure all parties understand how to comply and maintain safety. ABIC recommends Queensland Health collaborate with industry to produce a set of guidelines or a practice standard for nurse-led cosmetic injectable services. Topics to cover include:

- **Cold-chain management:** Proper storage and refrigeration of temperature-sensitive injectables (with reference to national vaccine storage guidelines which can be repurposed).
- **Documentation standards:** How to document telehealth prescribing consults, treatment records, before/after photographs with patient consent, etc., in a way that is transparent and auditable.
- **Informed consent protocols:** Ensuring patients are well-informed of the qualifications of their provider (e.g., they should know a nurse is treating them and a doctor authorised it remotely), and of the risks/benefits of the procedure.

- **Emergency protocols:** Each clinic should have a written emergency response plan for adverse events (e.g., an anaphylaxis kit on site and training in its use, a supply of hyaluronidase for filler complications, and a protocol on when to transfer to hospital). Many clinics already have these; making it an official guideline ensures uniform adoption.
- **Oversight procedures:** Clarify how remote oversight works. For instance, a guideline might suggest that the collaborating doctor should review a sample of patient files monthly, or that they should physically visit the clinic quarterly to observe practices, or that they hold regular case discussions with the nurse. While not all of these need to be mandated, setting expectations helps maintain a high standard.
- **Scope of practice boundaries:** Emphasise that RNs cannot and should not practice beyond certain limits – e.g., they should not treat without a prescription, should not undertake procedures for which they are not trained (like certain advanced off-label uses perhaps), and must refer to or involve medical practitioners when a case is outside their competence (e.g., a patient with complex medical history or a complication needing medical treatment).
- **Advertising and ethical practice:** Reinforce existing rules (like the TGA's ban on advertising S4 product brand names, appropriate use of social media, etc.) to ensure the business side of cosmetic practice remains ethical and doesn't promote unrealistic expectations.

ABIC has resources and templates addressing many of these points, and we would be happy to contribute them. We believe most nurse-led clinics want to be compliant and safe, often they simply need clear, authoritative guidance on what is expected. By providing this, Queensland Health can actually achieve a higher level of compliance than existed previously, now that everyone's attention is on regulatory requirements.

5. Establish a Stakeholder Working Group for Ongoing Oversight and Co-Design

As part of the solution, ABIC proposes the formation of a Queensland Cosmetic Injectables Regulatory Reference Group. This would be a taskforce or committee including:

- Representatives from Queensland Health (Medicines Regulation Unit, possibly Chief Nurse or Chief Medical Office input).
- ABIC representatives (which could include experienced cosmetic RNs, a cosmetic physician, and an industry regulation expert).
- A patient/consumer representative might also be considered, to keep patient interests central.

The remit of this group would be to:

- **Monitor the implementation** of the new EPA/permit system – addressing any teething issues, clarifying ambiguities, etc.
- **Gather data** on outcomes – e.g., number of permits issued, any adverse events reported, compliance rates, etc., to evaluate the effectiveness of the reforms.
- **Advise on further improvements** – the cosmetic industry evolves with new treatments and products; this group could foresee and advise on any future regulatory needs (for example, if new types of injectables come to market).
- **Provide a channel of communication** between industry and regulators – to ensure issues are flagged early and dealt with collaboratively rather than adversarially.

ABIC's impact report explicitly suggested establishing such a stakeholder reference group to support ongoing engagement. We view this as crucial for maintaining trust. The events of the past months show the consequences of a disconnect between industry and regulators (confusion, resentment, and non-compliance). A regular forum where we can talk through concerns would prevent that gap from widening again.

We'd suggest this group meet regularly (e.g., quarterly) and report annually to the Health Minister or Director-General on the state of the cosmetic injectables sector, compliance, and any recommendations. This would keep the Government informed and ahead of any emerging issues, thereby supporting a dynamic regulatory environment that can adapt without resorting to drastic measures.

6. Summary of Recommendations

To summaris e in list form, ABIC's formal recommendations are:

1. **Issue an Extended Practice Authority for RNs (Cosmetic Injectables):** Empower qualified registered nurses under defined conditions to purchase, possess, and administer S4 cosmetic medicines in nurse-led clinics, via an EPA instrument. This should be done as an urgent interim measure to immediately restore lawful operation for nurse practitioners in this field.

2. **Implement a Cosmetic Clinic Poisons Permit Scheme:** Amend regulations to allow nurse-led clinics or individuals to obtain a state permit or license to hold S4 injectables as stock for cosmetic use, with appropriate supervision arrangements (modelled on Victoria's successful framework).

3. **Legislative Amendment for Clarity:** Progress amendments to the MPMR (and if needed the MPA) to explicitly authorise RN-led administration of cosmetic S4 medications under oversight, aligning Queensland's law with national best practice and eliminating ambiguity that led to the current restrictions.

4. **Robust Safeguards and Criteria:** In implementing the above, include strict criteria and safety measures – e.g. require specific training/experience for participating RNs, enforce proper storage and record protocols, mandate collaboration with a prescriber, and require adverse event reporting and continuing professional development in cosmetic pharmacology. These measures will ensure public safety remains paramount.

5. **Guidance and Education:** Publish comprehensive guidelines (in partnership with industry) for cosmetic injectable practices under the new framework, covering safe handling of medicines, clinical best practices, documentation, and legal responsibilities. Additionally, provide outreach and education to affected clinics to help them transition to the compliant model, this could include webinars, FAQ documents, and a hotline for regulatory advice.

6. **Stakeholder Reference Group:** Establish a formal working group with industry and clinical stakeholders to monitor implementation, advise on policy adjustments, and ensure ongoing communication between Queensland Health and the cosmetic injectables sector.

7. **Interim Relief:** In the immediate term (while the above measures are being formalised), adopt an enforcement moratorium or grace period for nurse-led clinics that are making genuine efforts to comply. Queensland Health indicated an initial approach of educating non-compliant clinics rather than closing them. We urge that no clinics be forced to shut doors or face punitive action if they are in transition to the new framework. A written assurance of this would go far to stabilise the industry as changes roll out.

8. **Evaluation and Review:** Commit to reviewing the outcomes of these reforms after, say, 12 or 24 months. Define success metrics such as: no increase in adverse events, high uptake of compliance measures, sustained or improved patient access, and retention of workforce. If objectives are not met, stakeholders can reconvene to adjust the approach. However, based on other jurisdictions and historical data, we anticipate positive outcomes.

Each of these recommendations addresses a facet of the issue: legal authority, safety control, guidance, and collaboration. Together, they form a comprehensive solution that can be enacted with urgency and thoughtfulness.

Stakeholder Impacts of the Proposed Reforms

Adopting the recommended reforms will have wide-ranging positive impacts across various stakeholder groups:

- **Patients and the Public:** The public will benefit from continued access to safe and affordable cosmetic injectable services in Queensland. They will have the assurance that whether they go to a nurse-led clinic or a doctor's clinic, the providers are operating under a regulatory framework that is sanctioned by Queensland Health. Patients in regional areas will not lose local services and will avoid the need to travel long distances or seek risky alternatives. Overall, patient safety is preserved (even enhanced, through standardised protocols) while patient choice and convenience are protected. The public can also be confident that regulators are actively overseeing this space via permits and reporting, increasing trust in the cosmetic industry as a properly regulated part of healthcare.

- **Registered Nurses (Cosmetic Injectors):** Nurses will regain the ability to practice their specialty with legal clarity and professional dignity. They will be able to continue running their clinics or working in their roles without fear of inadvertently breaching laws. This will undoubtedly improve morale and mental wellbeing among this workforce. Economically, they can earn a livelihood and grow their businesses, contributing to Queensland's economy. The reforms also encourage them to continually upskill and adhere to best practice, since those are conditions of being allowed the privilege to hold S4 meds. The feeling of being a trusted and integral part of the healthcare system will be a powerful motivator for ongoing compliance and excellence.

- **Medical Practitioners and Nurse Practitioners:** Doctors will still maintain their crucial role as prescribers and overseers, but with greater flexibility. They can extend their services through collaborative agreements without the impractical burden of physical presence everywhere. Responsible doctors will appreciate having clear guidelines to work with nurses (rather than operating in a grey area). They also benefit because the patient base for cosmetic treatments remains robust, if nurse clinics closed, many patients might drop out altogether, which doesn't help doctors either. The reforms may spur more doctors to join forces with nurses in innovative practice models, knowing it's officially supported. Additionally, by removing the unrealistic requirement of on-site presence, doctors can allocate their time more efficiently, focusing on consultations, complex procedures, or other medical work, thereby improving overall healthcare resource utilisation.

- **Queensland Health and Regulators:** From the regulator's perspective, these changes mean moving from an adversarial enforcement posture to a cooperative regulatory posture. Instead of expending resources policing an outright ban (which could be a losing battle if underground activity grows), regulators can channel efforts into managing a known cohort of licensed practitioners. They'll have better visibility on who is practicing and how, thanks to permitting and reporting systems. By engaging with industry via the working group, regulators gain a deeper understanding of the sector dynamics, enabling smarter policy in the future. Importantly, should any isolated bad actors operate unsafely, regulators can intervene on a case-by-case basis (e.g., revoke a permit or impose penalties) without disrupting the entire industry. This targeted risk management is far more efficient. In terms of public relations and trust, Queensland Health would be seen as responsive and pragmatic, enhancing its standing among both professionals and the public.

- **Economic and Community Impact:** The broader Queensland community benefits from retaining the economic activity of these businesses. The sector's revenues continue to circulate locally, clinics buy supplies, pay rent, employ staff, pay taxes, rather than seeing that economic activity shrink or flow to other states. Preserving hundreds of small businesses also sends a message that Queensland supports entrepreneurship and values the contribution of niche industries. There's also a multiplier effect:

clients visiting cosmetic clinics often spend money in nearby businesses (cafes, retail) as part of their outing, so keeping clinics open supports those incidental expenditures too. Moreover, by keeping these mainly female-run businesses viable, Queensland strengthens community diversity and inclusion in commerce.

- **Workforce Planning and Healthcare System:** On a strategic level, keeping nurses in active practice in their field means those skills remain in Queensland's talent pool. Should there ever be a need (for instance, if the public health system wanted to tap into skilled injectors for mass vaccination programs or other procedures), those nurses are available and in-state. If they had been driven away or out of healthcare, that flexibility would be lost. Also, maintaining this outlet for nurses possibly helps keep some nurses in the profession overall; a nurse who leaves cosmetic injecting might not return to bedside nursing, they might leave nursing entirely or move. Given that Australia often faces nursing shortages, every trained nurse we retain in the health sector (even the cosmetic sector) is valuable. A happy healthcare workforce in any domain is one less likely to burn out and one more likely to contribute positively to the community (some cosmetic RNs also do volunteer work or shifts in aged care etc., which they could not continue if their primary income vanished).

- **Gender Equity and Social Considerations:** Implementing these reforms would demonstrate that Queensland's government is attentive to gendered economic issues. It would mitigate what has been a disproportionate impact on women practitioners. This aligns with wider government initiatives to support women's economic security and participation. Furthermore, supporting female healthcare entrepreneurs has social benefits, as these leaders often mentor others and invest in community initiatives. The case studies showed nurses taking on apprentices and nurturing new talent, something that would have been cut short. With their businesses intact, they can continue to foster the next generation of skilled workers.

- **Educational Institutions:** Don't forget stakeholders like training organisations, colleges that offer courses in aesthetic nursing and dermal therapies. The reforms will ensure there is a clear career path in Queensland for graduates of these programs, thereby sustaining enrollment and the education sector's contribution. Without reform, student nurses might shy away from cosmetic specialisations seeing no future in QLD, which would hurt those training providers and lead to loss of expertise.

In essence, the proposed approach is a win-win: it addresses the government's safety concerns in a smarter way, while avoiding the severe downsides of the current restrictions. It allows each stakeholder to function in their optimal capacity, together forming a safer and stronger cosmetic healthcare ecosystem for Queensland.

Conclusion and Call to Action

Urgency of Action: The situation facing nurse-led cosmetic clinics in Queensland is urgent and unprecedented. In a matter of months, an entire segment of legitimate healthcare practice has been pushed to the brink, not by market forces or malpractice, but by a regulatory interpretation that, however well-intentioned, did not account for on-the-ground realities. The consequences, clinic closures, job losses, patient access issues, and potential safety risks from unintended outcomes are not hypothetical future concerns, they are unfolding right now. Every week of delay in implementing a solution means more livelihoods devastated, more patients inconvenienced or exposed to risk, and more economic loss for the state.

ABIC therefore implores Queensland Health and the Government to treat this as a priority crisis, akin to how one would respond to any public health emergency or urgent industry collapse, with swift, decisive, but well-considered action. We have outlined exactly such an action plan: one that can be initiated immediately via administrative mechanisms (EPA and enforcement discretion) and cemented through regulatory and legislative updates.

Feasibility and Pragmatism: The reforms we propose are entirely feasible. They do not require re-inventing the wheel; they largely mirror systems already working in other Australian states or in other practice areas within Queensland. This means Queensland can draw on existing models and expertise to implement them. It also means that the risk of the unknown is low, we can be confident these measures will work because they have

worked elsewhere. The Government can implement these changes knowing it is on solid ground both legally and in terms of patient safety evidence.

Public Interest and Safety: Far from compromising patient safety, these changes will enhance protections by bringing practitioners into a structured framework with clear rules and oversight. A nurse operating under a Queensland Health-issued EPA and permit, adhering to mandated protocols, is arguably more accountable than one who was operating under an informal understanding of the law. We thereby achieve the dual goal of safeguarding the public and preserving services. It is rare in public policy to have such a clear win-win option where no stakeholder is harmed, in this case, even those originally worried about safety (perhaps some in the medical community or regulatory bodies) can be assured that our proposal does not dilute safety one iota; it in fact reinforces it through official recognition and monitoring.

Modernising Healthcare Regulation: On a higher level, by embracing these reforms Queensland has an opportunity to position itself as a leader in forward-thinking, evidence-based healthcare regulation. The cosmetic injectables issue is a test case that pits outdated rigid interpretation against modern risk-based regulation. By choosing the latter, Queensland sends a message that it trusts its health professionals and is adept at calibrating policy to real-world data. This fosters an environment of innovation which is critical not just in cosmetic medicine but across the board as healthcare evolves with new technologies and roles (think of emerging fields like nurse endoscopists, physician assistants, etc.; how we handle this situation may set a precedent for welcoming new practice models responsibly).

Support and Collaboration: ABIC reiterates our full commitment to being part of the solution. We are not simply asking the Government to fix a problem; we are offering our partnership and resources to help implement the fix. We can assist in drafting guidelines, educating our members about any new requirements, facilitating the collection of data on outcomes, and continuing dialogue to fine-tune the regulatory approach. We appreciate that Queensland Health has signalled willingness to engage and we stand ready to engage constructively and promptly.

In particular, we would welcome an immediate meeting or forum with Queensland Health officials and the Health Minister's office to discuss the details of enacting an Extended Practice Authority and permit scheme. Time is of the essence, but ABIC has already done substantial groundwork (as evidenced in this submission) that can accelerate the process.

The nurses affected have organised themselves under the ABIC Regulation Committee, as the **Queensland Aesthetic Nurses United** working group and are ready to comply with whatever new system is put in place, they simply seek the chance to do so before their businesses collapse irreversibly.

A Landmark Opportunity: This submission is more than an advocacy document; it is an invitation for Queensland to craft a landmark regulatory solution that could become the gold standard nationally. By solving this issue in a balanced way, Queensland can lead Australia in establishing a consistent national model for cosmetic injectable practice. We foresee that other states and the Federal arena (Ahpra, etc.) will be watching the outcome here. A positive resolution could inform future national guidelines or even harmonisation efforts. In that sense, what we do now is pioneering for the entire country's approach to cosmetic medicine governance.

Final Appeal: We urge the Queensland Government to act swiftly on the recommendations set forth. Lives and livelihoods are quite literally hanging in the balance. The path forward we propose is grounded in fact, law, and ethics. It ensures that:

- The public is protected, not by banning practitioners, but by binding them into accountable practice.
- Healthcare professionals are empowered to deliver services to the top of their training, with appropriate checks in place.
- Queensland's laws are consistent with the rest of Australia, preventing our state from falling behind or losing valuable workforce.

- The economy and small businesses are safeguarded, particularly those led by women, thereby reflecting the Government's broader social and economic objectives.

In closing, ABIC is confident that through collaboration and reasoned reform, Queensland can resolve the current challenges in a manner that strengthens the regulatory framework and maintains Queensland's reputation for high-quality health standards. We respectfully request that the Government give this submission due consideration and move to implementation without delay.

Prepared on behalf of the Aesthetic Beauty Industry Council (ABIC)
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