Consumers Health Forum of Australia

SUBMISSION

PHARMACIST PRESCRIBING:

PHARMACY BOARD OF AUSTRALIA DISCUSION PAPER

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Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health consumer affairs. CHF works to achieve safe, quality, timely and affordable healthcare for all Australians, supported by accessible health information and systems. CHF is pleased to make this submission in response to the discussion paper on pharmacy prescribing produced by the Pharmacy Board of Australia.

Consumers regard the prescription of medicines – who can prescribe and under what conditions - as a key safety and quality issue. CHF has been a strong supporter of the National Medicines Policy and is a champion of the Quality Use of Medicines (QUM) approach within that policy. We were encouraged to see that the discussion paper highlighted the need for any proposed model of pharmacist prescribing to contribute to and support QUM.

CHF has been pursuing a reform agenda for primary health care that puts the person at the centre of care and builds a system around their needs. CHF has taken a strong interest in the role of pharmacists and is keen to see them integrated into the primary health care system. In consultations we have undertaken consumers have consistently indicated that they see the pharmacist as part of the primary health care team and are looking for improved collaboration between pharmacists and other health professionals with the emphasis on them providing complementary services rather than being in competition[1].

In this submission we look at how pharmacist prescribing fits into that team approach and how it can be configured to maximise safety and quality in the use of prescription medicines whilst ensuring people have adequate access.

Key Issues

Access to prescription medicines

We note that the discussion paper starts with the premise that there will be a shortage of prescribers. We are, of course, concerned about anything that means people do not get the right medicines at the right time.

However, we have not had feedback about this being a problem for consumers and it did not figure in the results of our 2015 survey. We question if there really is an overall shortfall but accept that there may be regional or localised shortages. Clearly we need solutions where that is the case and it may be that there needs to be a range of options designed for local needs with pharmacists in identified high need areas able to take on a more autonomous role than in areas where there is a good supply of other prescribers.

[1] CHF 2015 Pharmacists and Primary Health Care Consumer Survey

The benefits to consumers of pharmacists being able to prescribe, even under the structured and supervised models, are clear in terms of access and convenience. Pharmacists are more geographically distributed and are sometimes the only primary health provider in a small rural community. Giving those pharmacists some prescribing rights makes some sense in terms of improving access for those communities.

The autonomous prescribing model has the most impact in terms of reducing the workload of other prescribers and possibly filling gaps where they exist.

The other models still require ongoing input from the doctor or other health professional and so have less of an impact.

Other ways to meet demand for prescription medicines

The paper only looks at ways we can increase the number of prescribers and sees pharmacists as being able to help fill the shortfall. It is worth noting that there could be a case for saying that increasing the number of prescribers actually increases the number of prescriptions i.e. we could have supply-led demand. It does not look at other options to meet, or even reduce, the prescribing needs of the community.

Earlier this year there was a proposal to increase the size of a prescription so that it could last two months. This would have decreased the need for prescribers, in fact halving the call on them for the medicines to be included in such an arrangement. It was not supported by the Pharmacy Guild of Australia or the Pharmaceutical Society of Australia despite being something identified by consumers as improving their access to the medicines they need.

There is a need to look at ways we can reduce the prescription of medicines. We have come a long way on this in encouraging doctors to take a more cautious approach to prescribing in terms of antibiotics and are looking to decrease a range of others. We are also looking at ways to de-prescribe and reduce polypharmacy, particularly amongst older people and people with chronic conditions. There is also a growing interest in social prescribing to replace prescription medicines with other interventions. All of these could change the dynamics and reduce the need for more prescribers.

Safety and quality

Consumers value safety and quality at least as highly as they do convenience and, in many cases, would opt for less convenience to have the guarantee of safety and quality. Pharmacists are not doctors and consumers would have serious concerns about prescribing, particularly autonomous prescribing, taking them into the diagnostic field for which they are not trained. In our 2015 survey of consumer attitudes to services provided by pharmacists' consumers raised concerns about the training and competency of pharmacists to deliver a broader suite of services.[2]

[2] CHF 2015 Pharmacists and Primary Health Care Consumer Survey report

If we move to this new enhanced role for pharmacists the we need to think through what training and accommodation will be necessary to give consumers the confidence that these services do not compromise the quality they have come to expect from GP. To reassure consumers there may be a need to have an advanced pharmacist role that shows the pharmacist has undertaken additional education and training in prescribing. This could be an expansion of the current consultant pharmacist role.

This does raise the issue that not all pharmacists in a pharmacy might have the additional training. This would mean prescribing could only be done at specific times and would diminish the impact on the number of prescribers.

Separation of prescribing and dispensing

CHF does have a concern that there could be a conflict of interest where the pharmacist is the prescriber and the dispenser. Separation of prescribing and dispensing should be a fundamental principle. This inherent conflict has been recognised and is one of the reasons why there is not co-location of pharmacy within GP practices in Australia.

The structured and supervised prescribing models overcome this problem to some extent as the GP or other health professionals is the initiator of the treatment which the pharmacist then continues. The continuous loop of exchange of data and review that is in such a model should ensure prescribing is appropriate for the patient.

Recommendation

CHF supports a cautious approach to moving towards greater involvement of pharmacists in prescribing. Consumers have made it clear that they want more collaboration between pharmacists and treating doctors and see their services as complementary rather than substitutes for each other. Making pharmacists prescribers should not be the only solution to problems with access to medicines.

However, we accept that it is worth looking at this as one of the possible ways to reform primary health care. We need to make sure we do not compromise safety and quality for convenience. If pharmacists are to move into prescribing roles then CHF recommends the initial move to be prescribing under a structured prescribing arrangement (Option 1 in the discussion paper). This will encourage collaboration, build trust between the professions and build confidence in consumers with the enhanced role of pharmacists. These rights need to be restricted to Schedule 4 medicines, and perhaps a restricted list of those. That list could either be a list of what can be prescribed or, perhaps more usefully, a list of what cannot be prescribed. We do not support pharmacists being able to prescribe Schedule 8 medicines.

There could be a move to a more autonomous role for pharmacists in areas of identified workforce shortage of other prescribers, particularly in rural and remote areas but again we would be cautious about this. It would need to have additional robust safeguards built in

around collaboration with a doctor and possibly time limits on number of prescriptions that the pharmacist can give without a referral back to a treating doctor.

This needs to be thoroughly evaluated before there is any move to a more autonomous regime, with an emphasis on patient experience and outcome measures in that evaluation as well as a careful look at any emerging safety issues.