Submission to the Pharmacy Board of Australia – Pharmacist Prescribing

1. About the RACGP

The Royal Australian College of General Practitioners (RACGP) is Australia's largest general practice organisation, representing over 40,000 members working in or towards a career as a specialist general practitioner (GP). The RACGP advocates for and supports GPs, general practice registrars and medical students.

2. RACGP position

The RACGP does not support the expansion of pharmacists' scope of practice beyond their core function of medicine advice and dispensing, into prescribing. The provision of medical services by health professionals lacking the necessary medical training or registration is an inappropriate and unsustainable solution to address the health needs of Australians.

In summary, the RACGP strongly opposes the models proposed by the Pharmacy Board of Australia for the following reasons:

- the discussion paper fails to address why pharmacists should work outside their scope of practice and prescribe medications
- it is not clear what the issue is and why pharmacist prescribing is the solution
- duplication of existing primary healthcare services will invariably lead to fragmentation of care
- pharmacists do not have the knowledge to support safe prescribing and are not equipped to provide opportunistic preventive care and chronic disease management
- patients will be exposed to unnecessary risk, including increased incidences of medication misadventure
- the business needs of a pharmacy may be prioritised over the needs of patients
- burdens on GPs (both time-related and indemnity-related) would increase.

Recommendation:

The models proposed by the Pharmacy Board of Australia in their discussion paper must not be applied in the primary care setting.

Note: The feedback within this submission relates to the impact of the proposed models of prescribing in the primary healthcare setting only.

3. General feedback

The Pharmacy Board of Australia has outlined three models of pharmacist prescribing. It appears that the consultation is considering 'how' pharmacists should prescribe, without appropriately considering whether pharmacy prescribing is appropriate at all. We know that many medical professions, and even pharmacists themselves, consider it inappropriate that pharmacists expand their role into prescribing. (1,2)

GPs are central to healthcare stewardship and coordination – any programs and initiatives relating to the health of a patient must be coordinated through the patient's usual GP. Patients whose care is continuous and coordinated have lower rates of hospitalisation and emergency department attendances, as well as lower mortality rates. (3,4) Multiple health professionals offering the same services will compromise appropriately coordinated care and adversely affect health outcomes.

Pharmacists, like all health professionals, add value when working at their highest level within their scope of practice. For pharmacists, this means providing services related to the safe, effective and efficient use of medicines. The increasing push to expand the scope of pharmacy, subjects patients to the risks of fragmented care and wastes valuable and finite health resources.

The following concerns span across the three models proposed in the Pharmacy Board of Australia discussion paper:

3.1. Addressing an issue that doesn't exist

Any program that seeks to duplicate existing primary healthcare services will invariably lead to fragmentation of care. Any expansion of health professional roles in primary care must be carefully considered as to whether it will improve or hinder health outcomes for patients.

It is unclear what issue the proposed models intend to solve. While the discussion paper notes that the models could improve medication management, it is not clear how pharmacist prescribing would achieve this. There are many other models and mechanisms that can be explored to improve medication management that would not require pharmacist prescribing.

3.2. Patient access to general practice and pharmacy

Improved patient access and convenience is often referenced as a reason to expand the scope of health professionals. However, it is important to note that convenience does not necessarily equal quality healthcare. While allowing non-medical practitioners to prescribe may increase patient access, access to services alone does not benefit patients. Patients need access to safe, comprehensive, coordinated and high-quality health services.

However, in primary care, it is unlikely that access to medicines would improve with the expansion of prescribing rights to pharmacists. Patients already have significant access to quality prescribers through general practice. Each year, almost 90% of the population visit their GP for medical care (12). In contrast, only 70% of patients require a prescription and require a visit to pharmacy.(5)

There are over 6500 accredited general practices across Australia (6), compared to only 5,700 pharmacies. (7) The most recent comparable data suggests that GPs are far more accessible than pharmacists, regardless of rurality. There were 24,657 GPs in major cities, compared to 18,417 pharmacists. (8,9) This same trend occurs in very remote locations, where there were 709 GPs (8) compared to only 92 pharmacists. (9)

3.3. Impact on patient wait times

Another common argument is that patients experience long wait times to see their GP. However, data suggests that the majority of patients only wait four hours between making an appointment and seeing their GP (63%), and very few patients wait 24 hours or more (27%). (5)

Any new system of pharmacy prescribing will require pharmacists to spend time reviewing the patient. This will eventually, if not immediately, result in a need for appointments and increased wait times in the same way that occurs in general practice.

Therefore, patient convenience is unlikely to be improved. Furthermore, pharmacies are generally not configured to provide the privacy and examination facilities required to offer these services.

3.4. Insufficient knowledge to support safe prescribing

Pharmacists do not have the appropriate diagnostic skills required to identify all potential health issues that arise from a consultation. Attending to patients' health needs is not always as straightforward as it may initially appear, and the symptoms that present could be an indication of deeper health issues. Identifying these issues requires a comprehensive knowledge of a patient's history and the appropriate medical training spanning triage, diagnosis and treatment.

GPs undertake significant training that prepares them to offer safe and high-quality medical care. After five or six years of completing a Bachelor of Medicine and Bachelor of Surgery (MBBS), GPs then undertake two years of hospital training, followed by three years supervised general practice training. This is then followed by RACGP Fellowship examinations. In comparison, following a four year Bachelor of Pharmacy, pharmacists only undertake one year of supervised practice.

Pharmacists simply do not have the healthcare training required to safely deliver healthcare services. Expanding the pharmacist scope of practice to prescribing may result in unusual (and sometimes serious) conditions not being recognised and managed appropriately.

3.5. Missed opportunities for important preventive care and chronic disease management

A visit to the doctor is not just about a prescription. A recent analysis of over 1.5 million GP–patient encounters in Australia confirmed that most medication requests to GPs lead to additional healthcare needs being addressed during the same visit. (10)

When a patient presents to their regular GP for a planned or ad hoc consultation, a range of other opportunistic healthcare services are provided including:

- preventive health screening and advice
- health education
- updating of their health record
- building of the therapeutic relationship between patient and doctor.

Introducing a model for pharmacist prescribing could direct patients away from their general practice and reduce opportunities for essential preventive care.

3.6. Disregarding specially designed mechanisms to ensure quality prescribing

The Therapeutic Goods Administration already has a process in place for medications to be down regulated from schedule-four prescription-only medications to schedule-three pharmacist-only medications. The provision of schedule-four medications via pharmacy prescription will result in a de facto schedule-three classification. This goes against the expert, considered advice of the Therapeutic Goods Administration, and exposes patients to unnecessary risk.

In addition, the discussion paper notes that there should be clear separation of prescribing and dispensing, yet provides no detail on how this would be ensured under any of the proposed models.

3.7. Medication errors

The *Medicine Safety: Take Care* Report outlines that 250,000 Australians are hospitalised each year, with another 400,000 presenting to emergency departments, due to medication errors. The report identifies that the cost of medication-related problems in Australia is nearly at $1.4 billion – equivalent to 15 per cent of total PBS expenditure.

Multiple prescribers and the involvement of less qualified prescribers will inevitably risk patient safety and increase risk of medication misadventure.

Evidence shows that continuous care provided in the general practice setting is associated with increased adherence to medication. (3,11) Pharmacists and GPs can work together to minimise risks associated with medicines through models such as the general practice based non-dispensing pharmacist.

3.8. Flow on effects of increased risk

It is not clear from the discussion paper if pharmacists would be required to take out additional indemnity cover as part of the proposed prescribing models. The RACGP suspects that GPs' premiums would increase as they would be responsible for supervising a prescriber who could increase their own medico-legal risk. Should any of the proposed models be implemented, the RACGP recommends that pharmacists be mandated to take out a higher level of indemnity cover.

4. Feedback on the proposed models

The models for pharmacist prescribing proposed by the Pharmacy Board of Australia are not appropriate for the primary care setting.

4.1 Autonomous prescribing

Autonomous prescribing by a pharmacist in the primary care setting is inappropriate. The proposed model seeks to provide primary medical care to patients with no link to general practice. This will lead to fragmentation of care, and risks to patient safety.

This model would also lead to a two-tier primary healthcare system where patients who cannot access GP services (eg due to cost or geographic location) may instead see a pharmacist as their first point of contact.

No amount of training, other than the completion of a medical degree and specialist training, would be sufficient to support autonomous pharmacist prescribing. It is not possible to substitute the years of study and clinical practice undertaken by a specialist GP, or other medical specialist, with a minimum level of clinical experience and a postgraduate qualification.

The RACGP strongly opposes the implementation of autonomous pharmacist prescribing.

4.2 Prescribing under supervision

Under this model, pharmacists could prescribe under the supervision of another 'authorised prescriber'. Allowing pharmacists to prescribe under the supervision of an authorised prescriber, who is not a medical practitioner, in effect allows independent non-medical prescribing. For this reason, the RACGP does not support this model.

Even if this model was limited to medical prescribers only, it must be considered that ongoing supervision of pharmacists by medical practitioners such as GPs could potentially increase the burden on their time. This would therefore nullify any benefit of the prescribing under supervision model. Currently, there is no mechanism to support the time required for GPs to undertake such a supervisory role.

4.3 Prescribing under a structured prescribing arrangement

This model proposes developing guidelines, standing orders or protocols for pharmacists to prescribe scheduled medicines. It is unclear whether such arrangements could take into account the individualised nature of patient health needs.

This model does not appear to consider that a patient's diagnosis is not always stable, and requires constant re-evaluation. As GPs have long-term ongoing relationships with their patients, they already monitor their patients' changing requirements and are therefore best placed to continue doing so and prescribe accordingly.

Relying on the My Health Record (as the structured prescribing arrangement model suggests) or other forms of electronic records alone will not be sufficient to ensure integrated and coordinated care. Pharmacists do not have the clinical knowledge to interpret a patient's medical history. Access to a medical record is also no substitute for the ongoing therapeutic relationship between a patient and their GP.

Prescribing under a protocol or similar mechanisms may limit the provision of individualised and holistic care and therefore is not appropriate in primary care.

5. Further discussion

The changing nature of the pharmacist's role will inevitably affect general practice patients. It is important that discussions regarding the role of pharmacists continue to be undertaken in collaboration with the RACGP.

Please contact Ms Susan Wall, Program Manager – Funding and Health System Reform on [redacted] or [redacted] regarding any further consultation on this issue.

References

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