

# Pharmacy Board of Australia: Public discussion paper on pharmacist prescribing

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## Responses to discussion paper questions about pharmacist prescribing

Your feedback is sought on the questions outlined in the Pharmacy Board of Australia 'Public discussion paper on pharmacist prescribing' published on 4 March 2019.

**Please provide your feedback as a Word document (or equivalent)<sup>1</sup> by close of business on Monday 15 April 2019.**

Some of these questions request details of evidence to support your views or views of your organisation. This discussion paper and other reports about prescribing published by the Board reference published information and evidence about pharmacist prescribing locally and overseas.

The Board is seeking further details about additional evidence (published or unpublished) that you may be aware of or believe should be considered. Evidence could include information about new initiatives in practice currently being developed or in progress; or relevant information about prescribing by other non-medical health professions that may provide further information or evidence to inform pharmacist prescribing. For example, evidence may include data demonstrating cost effective health outcomes or qualitative data demonstrating patient satisfaction with pharmacist prescribing.

### Stakeholder Details

**Organisation name:** The Pharmacy Guild of Australia

**Contact name:** [REDACTED]

**E-mail address:** [REDACTED]

### NOTE:

**The Pharmacy Guild has restricted its comments to Autonomous Prescribing as it does not believe that the other two options are feasible and will not address any of the public needs for improving medicines access and management.**

**If pharmacists are to address the public need for improving medicines access and management then all pharmacists across the community pharmacy network need to practice to their full professional scope and neither of the first two options allows this.**

### PUBLIC NEED

**1 How would autonomous prescribing by pharmacists fulfil a public need?**

- ***Australian's spend \$738 million in out of pocket expenses for Medicare-funded GP visits in 2016-17.***
- ***1.3 million Australians delayed or did not seek health services when they needed them because of cost.***
- ***UK research shows that pharmacist prescribing is as safe and effective as doctor prescribing.***

*Source: Australian Institute of Health and Welfare analysis of MBS claims data, 2016–17.*

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Autonomous prescribing would be the only effective method to fulfil the public need as mentioned in the discussion paper.

Pharmacists are as trusted as general practitioners by the Australian public and this trust can be leveraged so pharmacists can administer basic healthcare services to drive down costs to patients and the health budget, reduce waiting times, and increase accessibility. Autonomous pharmacist prescribing would improve access to treatment options for simple conditions that can be managed by a pharmacist – including after hours and weekends when access to other health care professionals is limited or non-existent.

The other models are dependent on another prescriber and would therefore be less effective. If pharmacist prescribing is to contribute to the delivery of sustainable, responsive and affordable access to medicines then prescribing has to be autonomous. Prescribing under a structured prescribing arrangement or under supervision relies on another health care professional and will therefore not be flexible enough to meet the needs of all Australians who for example may live in a rural or remote area where there is no or very limited access to a medical doctor or nurse practitioner. Other examples include after hours, palliative care, aged care or addiction medicine where an autonomous pharmacist prescriber will be able to provide the necessary care.

The Autonomous Pharmacist Prescriber will be no different to a Nurse Practitioner where the pharmacist will provide the necessary care within their individual scope of practice and work collaboratively with other members of the health care team, with the primary purpose being to best meet the health needs of the consumer. Pharmacists in Australia have already proven with influenza vaccination programs that they can be trained to prescribe and administer vaccines with reporting to the Australian Immunisation Register (AIR). Where a service is not an undergraduate competency the Australian pharmacy sector has proven that retro-fitting is possible with additional training to achieve this competency and deliver the services to Australians.

Overseas experience would suggest that it is not worthwhile to progress such models as Structured or Under Supervision and that efforts should be concentrated on Autonomous Prescribing as the single most appropriate goal. We believe that “structured” or “under-supervision” models would become a barrier to pharmacists participating in regional and remote areas where a supervisor would be unavailable. Ironically, it is these remote and rural areas where an autonomous prescribing pharmacist would improve access to medicines and treatment for simple conditions.

## **EVIDENCE (published or unpublished)**

### **2. What is the evidence that these models of prescribing by pharmacists would be a safe and effective way of improving access to medicines for the community?**

Autonomous prescribing by pharmacists has been implemented in some Canadian provinces and in the UK. As mentioned in the Discussion Paper the Canadian province of Alberta has implemented a model that correlates to autonomous prescribing and this is the Guild’s preferred option. We believe that pharmacists in every state and territory in Australia, with additional education, should be able to autonomously prescribe all medicines required in their particular practice. We do not believe that there should be an exception for Schedule 8 medicines as pharmacists in Addiction Medicine practices or Palliative Care practices will need to be able to prescribe these medicines.

As highlighted in a paper by Bhatia et al<sup>2</sup> in the past decade, pharmacist practice has evolved tremendously in Canada, but the scope of practice varies substantially from one province to another. As stated in the paper, though most provinces allow emergency prescribing and renewal or adaptation of prescriptions by pharmacists, only four provinces allow prescription initiation, with variable criteria and scope. Despite some progress to enhance patient flow through the health care system (e.g. by allowing pharmacists to extend prescriptions), further work is required to harmonize clinical practices across Canada and to enable pharmacists to initiate and manage medicine therapy. The Guild does not want to see a similar situation in Australia where pharmacist practice differs from State to State, as this is not in the best interest of meeting the consumers’ health care needs. Such a situation has the potential to add to confusion and limit the uptake of service. It would also fail to adequately contribute to addressing the workforce shortages in areas of need. Whilst we accept that one State may implement the initiative independently, our preference would be that all States and Territories need to implement autonomous prescribing for pharmacists and other medical professionals on a consistent basis across the country.

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<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5659246/>

*The Queensland pharmacist immunisation pilot phase 1 pharmacist vaccination – influenza final report*<sup>3</sup> showed that a pharmacist-delivered vaccination service is feasible in community pharmacy and is safe and effective. The accessibility of the pharmacist across the influenza season provided the opportunity for more people to be vaccinated, particularly those who had never received an influenza vaccine before. Patient satisfaction was extremely high with nearly all patients happy to recommend the service and to return again the following year. The fact that pharmacists can be trained to administer vaccines safely and effectively in Australia shows that pharmacists can be trained to extend this to other prescription medicines to ensure improved access to medicines for all Australians.

### **3. What is the evidence that these models of prescribing by pharmacists support the *Quality Use of Medicines (QUM)*, i.e. judicious, safe, appropriate and efficacious use? (For example, by minimising overuse of medicines, reducing adverse events, improving health outcomes and/or other elements outlined in QUM)**

A paper by Sue Latter et al “Evaluation of nurse and pharmacist independent prescribing”<sup>4</sup> was commissioned following the opening up of the British National Formulary to independent nurse and pharmacist prescribers in 2006. It was conducted to provide a national evaluation of nurse and pharmacist independent prescribing in England and the following are a summary of the key points:

- Between 2% and 3% of both the nursing and pharmacist workforce are qualified to prescribe medicines independently
- 93% of nurse prescribers and 80% of pharmacist prescribers had used their independent prescribing qualification. 86% of the nurses and 71% of the pharmacists were currently prescribing.
- Nurses and pharmacists are prescribing predominantly in primary care, with substantial numbers also in secondary care.
- Study results indicate that overall, nurse and pharmacist prescribing is currently safe and clinically appropriate.
- The study findings indicate that current educational programmes of preparation for nurse and pharmacist prescribing are operating largely satisfactorily, and provide fit-for-purpose preparation
- Evidence suggests that non-medical prescribing has been largely driven by individual practitioners to date, and has been used to increase the quality of existing services, as opposed to enabling service re-design

Another study by Wasim Baqir et al “*Pharmacist prescribing within a UK NHS hospital trust: nature and extent of prescribing, and prevalence of errors*”<sup>5</sup> concluded that “prescribing pharmacists can provide a valuable role in safely prescribing for a broad range of inpatients in UK general hospitals”.

Furthermore a Cochrane Systematic Review by Greg Weeks et al<sup>6</sup> pooled clinical outcomes and patients’ satisfaction across 45 studies of nurse or pharmacist prescribing compared with doctor prescribing. The Review found that prescribing by suitably trained pharmacists and nurses offers similar outcomes to prescribing by doctor, at least in the management of chronic conditions.

### **4. Are there any gaps in the evidence for pharmacist prescribing under these models? If so, how could this evidence be obtained?**

We do not believe that there are any gaps in the evidence for pharmacist prescribing under this model. We do not believe that any further evidence needs to be obtained as this particular model has been proven to be effective and safe in similar countries such as the UK and provinces in Canada such as Alberta.

## **EDUCATION AND TRAINING**

### **5. What education requirements (if any) would pharmacists with general registration need to complete to competently prescribe under each model? (i.e. postgraduate education)**

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<sup>3</sup> <https://eprints.qut.edu.au/91903/>

<sup>4</sup> <https://eprints.soton.ac.uk/184777/3/ENPIPfullreport.pdf>

<sup>5</sup> <https://ejhp.bmj.com/content/22/2/79>

<sup>6</sup> <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011227.pub2/full>

As identified in the paper by Lisa Nissen et al *“Pharmacist prescribing in Australia: An exploration of current pharmacist capabilities, required education and training to prescribe medicines and a process for moving forward”*<sup>7</sup> there are a number of prescribing competencies areas in which additional education and training would be required should autonomous prescribing be integrated into practice. As stated in this paper it is possible to identify specific elements essential to the prescribing process that require addressing within an education program designed to prepare pharmacists to prescribe autonomously and we would refer the Board to this paper for further details.

**6. Are current undergraduate program providers addressing the competencies to prescribe under each model? If not, what are the gaps and how can they be addressed?**

As above, current undergraduate programs address some of the competencies to prescribe. Identified gaps could be addressed and included in the curriculum of accredited degree programs leading to registration.

The Guild believes that as the scope of practice for pharmacists evolves and new activities become accepted as standard practice, these activities should be incorporated into the curriculum of degree programs so that graduates can enter their intern training with the knowledge and skills to deliver the health care that Australians have come to expect from community pharmacies.

Professional bodies would continue their role of training and developing the existing workforce to perform the new tasks associated with evolving scope of practice. We are confident that accredited training programs can be developed for currently registered pharmacists to update their skills so that they can be endorsed as autonomous pharmacist prescribers. This is no different to the process the profession underwent for pharmacists to become vaccinators.

**7. Before being authorised to prescribe under each model, would a pharmacist need to accumulate a minimum period of supervised practice under the supervision of an authorised prescriber (e.g. during the internship, before gaining general registration or after gaining general registration)?**

We note the following from the General Pharmaceutical Council’s website on Pharmacist independent prescriber<sup>8</sup>

- Applicants must have at least two years' appropriate patient-orientated experience post registration, in a relevant UK practice setting.
- To qualify as an independent prescriber a pharmacist must complete a GPhC- accredited program.
- After completion a pharmacist is eligible to apply for annotation on the register
- In addition to this, each pharmacist must successfully complete at least 12 days of learning in a practice environment whilst being mentored by a medical practitioner.

In the UK there are several universities that now offer GPhC-accredited conversion programs to allow supplementary prescribers to become qualified independent prescribers. We believe that this proves that the “supplementary” prescribing (similar to structured or under supervision – ie the first two columns) step is unnecessary and simply delays pharmacists contributing to best meeting the needs of patients. We believe that there should only be one type of pharmacist prescribing considered for Australia and that is the Autonomous Prescribing model. We should learn from the UK experience and work towards the only sensible option of Autonomous prescribing.

We also note that in Alberta, Canada a pharmacist may apply for additional prescribing authorization after meeting the following criteria<sup>9</sup>:

1. Have at least one year of full-time experience in direct patient care while on the clinical pharmacist register. Beginning in 2018, entry level Pharm D graduates from CCAPP accredited Canadian schools of pharmacy will have the one-year practice requirement waived. However applicants must use patient cases from their time on the clinical register as a clinical pharmacist (i.e. not as students, interns, etc.).
2. Have strong collaborative relationships with other regulated health professionals.
3. Have and maintain the necessary knowledge, skills, attitudes, and clinical judgment to enhance patient care.

<sup>7</sup> <https://www.pharmacyboard.gov.au/News/Professional-Practice-Issues/Forum-Pharmacist-prescribing.aspx>

<sup>88</sup> <https://www.pharmacyregulation.org/education/pharmacist-independent-prescriber>

<sup>9</sup> <https://abpharmacy.ca/additional-prescribing-authorization>

4. Have the required supports in his/her practice (e.g., access to information, communication, documentation processes) to enable safe and effective management of drug therapy.

Applications are evaluated by pharmacists who are trained to use an objective criterion-referenced assessment tool. Applicants that meet or exceed the minimum standard on review will receive authorization from the registrar to prescribe scheduled drugs in accordance with Sections 16 (3) and 16(4) of the Pharmacists and Pharmacy Technicians Profession Regulation.

These two examples would be used as a framework for implementation of pharmacist prescribing in Australia taking into consideration the requirements for supervised practice and minimum periods of practice experience.

#### **8. Before prescribing under each model, would a pharmacist need to have achieved a minimum period of practice experience as a pharmacist with general registration? If so, for what period?**

As above we would suggest that the UK experience would act as a suitable model for Australia. We note the “*Standards for education and training of pharmacist independent prescribers*” published by the General Pharmaceutical Council<sup>10</sup> state that applicants must have

- at least two years’ appropriate patient-orientated experience post registration.
- an identified area of clinical or therapeutic practice in which to develop independent prescribing practice
- a designated prescribing practitioner who has agreed to supervise their learning in practice.

#### **9. Would pharmacists prescribing under each model need to meet different annual CPD requirements to pharmacists who do not prescribe?**

All pharmacists who graduate from an Australian University should by the end of the Seventh Community Pharmacy Agreement be competent to be Autonomous Prescribers subject to supervised practice and minimum clinical experience, should they wish to be endorsed as such. All currently registered pharmacists will be able to complete a continuing education course that will update their knowledge. Therefore Autonomous Prescribing will be embedded as a core competency for all pharmacists in Australia and the CPD requirements will be the same and be determined by the Pharmacy Board of Australia.

We note that pharmacists who have been accredited by AACP to deliver Medication Management Reviews (which entitles the pharmacist to claim for remuneration for Home Medicines Reviews (HMRs) and Residential Medication Management Reviews (RMMRs)) must complete 60 CPD credits compared to 40 CPD credits for non-accredited pharmacists<sup>11</sup>. We would highlight that this is a requirement of AACP and not the Pharmacy Board of Australia.

The requirement for pharmacists to be accredited to deliver Medication Management Reviews is a barrier to the delivery of these services and we believe that this creates a barrier to access for some Australians. We believe that all Australian no matter where they live, rural, remote or urban, should be entitled to expect the same level of service from all community pharmacies. This is why we believe that Autonomous Prescribing should become a core competency of all practicing pharmacies so that they can deliver the same level of service from each and every one of the 5,700 community pharmacies across Australia.

A pharmacist’s scope of practice is determined individually and the pharmacist is required to plan their CPD on an annual basis. They must reflect on their role and the services they provide to identify professional development needs relevant to their identified competencies. Pharmacists who are autonomous prescribers will identify suitable CPD activities which address their professional development needs.

## **REGULATION**

#### **10. Would these models of prescribing by pharmacists require additional regulation by the Pharmacy Board or could it be adequately governed through relevant jurisdictional policy or legislation?**

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[https://www.pharmacyregulation.org/sites/default/files/document/standards\\_for\\_the\\_education\\_and\\_training\\_of\\_pharmacist\\_independent\\_prescribers\\_january\\_2019.pdf](https://www.pharmacyregulation.org/sites/default/files/document/standards_for_the_education_and_training_of_pharmacist_independent_prescribers_january_2019.pdf)

<sup>11</sup> <https://aacp.com.au/app/uploads/No-5-Reaccreditation-for-MMRs-May-2018.pdf>

An endorsement for scheduled medicines in accordance with Section 94 of the National Law would be required for pharmacists to prescribe under this model.

The Guild agrees that an endorsement is required and that currently registered pharmacists will need to complete an accredited training program to be eligible for endorsement. Current pharmacy degree programs of study will also need to be updated to ensure that all pharmacists graduating from an Australian University will be capable of Autonomous Prescribing when they complete their intern year, subject to meeting any supervised practice or minimum clinical experience requirements.

### **11. What are the risks associated with each model of pharmacist prescribing and how could they be managed?**

The Guild believes that with the first two options there is a very real risk that they will not provide the level of access for consumers to pharmacist prescribing that is required if the profession is to address the public need for improving access to medicines.

The first two options rely on an association with another prescriber and the pharmacist will not be able to deliver the care that the consumers require in such settings where this is no other prescriber. This requirement is a barrier to healthcare access and will not enable the pharmacist to deliver real and meaningful care to consumers such as those in rural and remote areas, those who require health care in after-hours settings or those in special care settings such as Addiction Medicine or Palliative Care.

We would remind the Board that under the National Medicines Policy there is a well-established endorsed framework based on partnerships between Governments (Commonwealth, States and Territories) health educators, health practitioners, and other healthcare providers and suppliers, the medicines industry, healthcare consumers, and the media working together to promote:

- quality care responsive to people's needs;
- incentives for preventive health and cost effective care;
- better value for taxpayers' dollars;
- more clearly defined roles and responsibilities; and
- continued universal access to basic health services through Medicare.

The National Medicines Policy (NMP) has four central objectives based on active and respectful partnerships, taking into account elements of social and economic policy. These central objectives, also referred to as the four pillars of the National Medicines Policy are:

- timely access to the medicines that Australians need, at a cost individuals and the community can afford;
- medicines meeting appropriate standards of quality, safety and efficacy;
- quality use of medicines; and
- maintaining a responsible and viable medicines industry.

If the profession is to develop a model of pharmacist prescribing that conforms to the pillars of the NMP then the most appropriate option to progress is Autonomous Pharmacist Prescribing. Autonomous Pharmacist Prescribing is the most effective option to deliver universal access to medicines management for all Australians.

We believe that the profession should concentrate on developing the policy changes required for Autonomous Prescribing because this will encompass the competencies of the other two options. To use resources to develop the policy changes for the first two options would not be an appropriate investment as demonstrated by the UK experience.

## **OTHER**

### **12 What factors would contribute to sustaining each model of pharmacist prescribing if introduced?**

We note from the UK experience that the "supplementary" model of prescribing was unsustainable and there has been a shift from this model to the Autonomous model as this provides the most effective and efficient means of pharmacists addressing the medicine management needs of the community.

The autonomous prescribing pharmacist model is self-sustaining as it would, like pharmacist vaccination, become a core competency of practicing pharmacists. Community pharmacy vaccination services have been enthusiastically received by Australian consumers. The Health Minister Greg Hunt announced in December 2018 that *“Australia experienced the lowest rates of the influenza since 2013 after a record 11 million Australians got a flu jab, nearly a third more than the previous year.”* In his Media Release statement, Mr Hunt stated that this would not have been possible without the collaboration between GPs and other vaccination providers across Australia, as well as community pharmacies which encouraged and administered the uptake of this important, life-saving vaccination.<sup>12</sup>

### 13 Do you have any additional comments about these models of prescribing by pharmacists?

- The Pharmacy Guild would caution against the jurisdictional variation of the Canadian prescribing model where there are differences amongst the provinces as to how pharmacists can practice and prescribe. This is evidenced by large variations in the numbers of pharmacists who have taken up prescribing across the different provinces. If there is to be pharmacist prescribing in Australia it would be preferable that it be implemented uniformly across all the States and Territories. For example, pharmacist vaccination was done on a state by state basis and therefore there are differences between the states and territories. The COAG has recently made a recommendation that there should be a process of harmonization of pharmacist vaccination across the country and is currently working towards harmonisation.
- Palliative Care prescribing by its nature would require the pharmacist to be able to prescribe Schedule 8 medicines and we believe that if a pharmacist is practicing in this area they should be allowed to prescribe this class of medicine. Likewise with Opioid Addiction Medication Services a pharmacist would need to be able to prescribe methadone and buprenorphine. Therefore we believe it is important not to restrict S8 prescribing from pharmacists but to highlight that it is dependent of their scope of activity.

We have to address the issue that prescribing and dispensing functions should be separated.

- Dispensing and prescribing. The Guild would endorse the AMA's policy for doctors who dispense and believe that this should also apply to pharmacists who prescribe. The following is an extract from the AMA's "Doctor's Relationships with Industry 2018"<sup>13</sup>

#### 13. Dispensing and related issues

- 13.1 Doctors who have a financial interest in dispensing therapeutic products including prescription medicines should be mindful of the possibility of actual or perceived conflicts of interest and take steps to manage them appropriately.<sup>7,8</sup>
  - 13.2 Doctors should only dispense therapeutic products that are evidence-based.
  - 13.3 Doctors should declare to patients their financial interests in dispensing therapeutic products.
  - 13.4 A doctor involved in the creation or development of a medical device or similar product may hold intellectual property rights in that device and receive royalty payments from its use. In such a situation, the doctor should declare to the patient their financial interest in the device before recommending its use in the patient's care.
  - 13.5 Doctors should not knowingly invest in industry manufacturing companies that will influence, or be perceived to influence, their professional judgment.
  - 13.6 Doctors should not be affiliated with industry manufacturers if the nature of their affiliation will influence, or be perceived to influence, their professional judgment.
- We would also note an article by David Lim et al in the Medical Journal of Australia titled *“Australian dispensing doctors' prescribing: quantitative and qualitative analysis<sup>14</sup>”*. This study concluded that contrary to overseas findings they found no evidence that Australian dispensing doctors overprescribed because of their

<sup>12</sup> <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt171.htm>

<sup>13</sup> <https://ama.com.au/position-statement/doctors-relationships-industry-2018>

<sup>14</sup> <https://www.mja.com.au/journal/2011/195/4/australian-dispensing-doctors-prescribing-quantitative-and-qualitative-analysis>

additional dispensing role. Likewise there would be no reason to suspect that pharmacists would overprescribe.