

March 2019

A mixed model is best for pharmacist prescribing

Grattan Institute submission to the Pharmacy Board of Australia discussion paper on pharmacist prescribing

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Overview

Pharmacies and pharmacists play a crucial role in the delivery of primary health care to the Australian community. Pharmacists are also key members of the health teams in hospitals. Improving the ability of the sector to deliver efficient, high-quality care to all is crucial to making Australia's health system more sustainable.

Using pharmacists' skills better – by allowing suitably prepared pharmacists to prescribe – will improve people's access to health care, facilitate better medication management, reduce costs, and ease the burden on general practice.

We recommend that pharmacists be allowed to prescribe under all three models proposed in the Pharmacy Board discussion paper: autonomous prescribing, prescribing under supervision, and prescribing under a structured prescribing arrangement.

Autonomous prescribing should be restricted to pharmacists employed in large hospitals, and prescribing under supervision should be restricted to hospitals and selected larger practices.

1 Pharmacists should be allowed to prescribe

Pharmacists are highly trained, have deep expertise in medicines, are among the most trusted of all professionals,¹ and are located in communities throughout Australia. Yet their role is far more limited in Australia than in many countries.

Australians miss out as a result. People have to wait longer and travel further to see a GP for a service that their local pharmacist could just as easily have provided. Sometimes people get sicker in the interim, which increases costs on the individual and the health system.

Evidence shows that pharmacists can safely provide repeat prescriptions to people with simple, stable conditions, and work with GPs to help patients manage chronic conditions. Allowing pharmacists to do so would improve the Australian health system by reducing pressure on the primary care system and improving people's access to care.

Pharmacists are already valued members of hospital health teams. Hospitals should be able to allow them to contribute even more.

¹ After nurses and on par with doctors. Roy Morgan (2016).

² At least 3.4 per cent of GP visits involve getting repeat prescriptions for problems previously treated by a doctor.

³ Some GPs don't require seeing a patient for a repeat prescription – they

1.1 Prescribing models might vary

Doctors generally write prescriptions for up to six months' supply of medicines. After this time, patients must return to get a new script, even if their needs have not changed. For people with long-term needs that are being successfully controlled by medication, these visits may not require the advanced skills of a GP.² Pharmacists could do the repeat prescribing instead.

Pharmacists should be able to continue medications for long-term conditions, when the patient and GP agree, and when the patient's condition is stable. It would be straightforward.³ After a GP has made a diagnosis and created a treatment plan, they would be able to share the patient's record with the pharmacist, if the patient agrees. Then, when the patient asked the pharmacist for a repeat script, the pharmacist could look up the patient's record, confirm the medication, and issue the script.

Depending on the condition, the GP could allow the pharmacist to issue continuing scripts for up to 18 months. Of course, if the patient's condition changed, they would have to return to their doctor to discuss their condition and review their medication.

Surveys of pharmacists in Australia suggest most are willing to take on this role, with further training.⁴ In many other countries,

might leave the prescription at their front desk, with or without a charge. See Duckett and Breadon (2013), p. 25.

⁴ Hoti, *et al.* (2010).

including Canada, England, the Netherlands, Scotland and the US, pharmacists are already doing it.⁵ And international studies suggest that pharmacist prescribing can improve patient health and access to treatment,⁶ and is welcomed by both patients and pharmacists.⁷

1.1.1 Pharmacists need to work closely with medical practitioners, especially in primary care

Broadening the role of pharmacists should not undermine GPs. The work of the pharmacist in primary care should only be in collaboration with the GP. For this reason, pharmacist prescribing in the community should be within the context of a structured prescribing arrangement with each GP.

Health Workforce Australia (2013) says prescribing under a structured arrangement:

occurs where a prescriber with a limited authorisation to prescribe medicines by legislation, requirements of the National Board and policies of the jurisdiction or health service, prescribes medicines under a guideline, protocol or standing order. A structured prescribing arrangement should be documented sufficiently to describe the responsibilities of the prescriber(s) involved and the communication that

occurs between team members and the person taking medicine.⁸

In this form of prescribing authority, the pharmacist would negotiate with each GP on what the arrangements are, and what authority the pharmacist has. This would give pre-eminence to the doctor-patient relationship, and ensure that the GP and the pharmacist are working in close collaboration.

Health Workforce Australia says prescribing under supervision:

occurs where a prescriber undertakes prescribing within their scope of practice under the supervision of another authorised health professional. The supervised prescriber has been educated to prescribe and has a limited authorisation to prescribe medicines that is determined by legislation, requirements of the National Board and policies of the jurisdiction, employer or health service. The prescriber and supervisor recognise their role in their health care team and ensure appropriate communication occurs between team members and the person taking medicine.⁹

This approach has some merit but should not be the way prescribing generally occurs outside hospitals. The 'under supervision' approach would allow a pharmacist, under the supervision of one medical practitioner, to change medications prescribed by a different medical practitioner, or to initiate new

⁵ Including emergency prescription refills, renewing/extending prescriptions, changing drug dosage/information, therapeutic substitutions, prescribing for minor ailments, and prescription drug treatment. Mossialos, *et al.* (2015).

⁶ Tsuyuki, *et al.* (2015); Backus, *et al.* (2015).

⁷ McCann, *et al.* (2015); Makowsky, *et al.* (2013).

⁸ Health Workforce Australia (2013).

⁹ Ibid.

medications for a patient not under the care of the supervising medical practitioner.

The only circumstances within which that should occur is if the pharmacist is subject to some form of accountability to both the supervising medical practitioner and to the medical probationer whose patients are having their medication changed. This might be appropriate where a pharmacist is employed in a group practice. It would also be appropriate in hospital care.

1.2 Pharmacists should be able to assist with chronic disease management

Managing chronic care is a significant and growing part of GP workload. More than half of GP visits involve managing at least one chronic condition.¹⁰ Many of these visits involve managing medications or adjusting dosages, rather than diagnosing conditions.

A large body of research suggests that chronic conditions are best managed in coordinated health care teams, which can deal with the complicated demands of treating chronic disease.¹¹ Australia has made headway in using practice nurses and chronic care coordinators, but there is also an important place for pharmacists in managing chronic disease.¹² They could:

- Review a patient's medication, check for any adverse drug interactions, and ensure that patients understand the medicines they are taking.
- Adjust doses and discontinue or alter the medication.
- Help treat acute conditions in chronic care patients, while avoiding adverse interactions with their existing medication.
- Give patients compliance packaging (with all the pills they need to take each day packaged together).
- Inform GPs and other health practitioners of any relevant information about the patient's care plan.
- Issue repeat prescriptions, as discussed above.
- Ensure medications are being used properly and safely, and identify any potential adverse reactions to drugs.

In many other countries, pharmacists are starting to do this. England and Scotland appear to be at the forefront of transforming the role of pharmacists in chronic disease management. Canada, the Netherlands and the US report more limited progress.¹³ There is increasing evidence of the benefits of

¹⁰ Swerissen and Duckett (2016).

¹¹ Proia, *et al.* (2014); Hirsch, *et al.* (2014).

¹² Some Australian pharmacies already offer partial chronic disease care (including smoking cessation and weight management) as part of their routine

practice. But they could do so more effectively if the care was more expansive and formally integrated into primary care-based disease management.

¹³ Mossialos, *et al.* (2015).

enabling pharmacists co-located with medical practitioners, to assist in the management of patients with chronic illness.¹⁴

Both pharmacists and physicians appear to favour a more collaborative approach to chronic disease management.¹⁵

International evidence shows pharmacist interventions significantly improve management of blood pressure, blood glucose and cholesterol levels.¹⁶ They can also improve self-care for patients with chronic conditions,¹⁷ potentially leading to a reduction in hospital admissions and therefore costs.¹⁸

¹⁴ Tan, *et al.* (2014).

¹⁵ Kelly, *et al.* (2013).

¹⁶ Santschi, *et al.* (2014); Tan, *et al.* (2014).

¹⁷ Zhong, *et al.* (2014); Ryan, *et al.* (2013).

¹⁸ Malet-Larrea, *et al.* (2016).

2 Pharmacists should be allowed to prescribe in hospitals

Pharmacists already play a major role in medication management in hospitals.¹⁹

Medication management in hospitals is very complex. Not all specialists in hospitals have extensive and advanced knowledge of medications and the interactions between medications. Specialists may not have knowledge of medications used outside their specialty. And junior doctors' knowledge of medication and medication interactions is still developing.

In these circumstances, pharmacist prescribing has an important role in improving patient care.

Hospitals have established clinical governance arrangements, and so pharmacist prescribing can be more autonomous in hospitals than in the community.

Health Workforce Australia says autonomous prescribing:

occurs where a prescriber undertakes prescribing within their scope of practice without the approval or supervision

of another health professional. The prescriber has been educated and authorised to autonomously prescribe in a specific area of clinical practice. Although the prescriber may prescribe autonomously, they recognise the role of all members of the health care team and ensure appropriate communication occurs between team members and the person taking medicine.²⁰

Although the definition refers to prescribing 'without approval or supervision', in effect the pharmacist is working within the guidelines and practices of the hospital. Pharmacists with autonomous prescribing rights should have their scope of practice delineated by the hospital in exactly the same way medical practitioners' scope of practice in the hospital is delineated.

Hospital pharmacists might also prescribe under supervision of a hospital doctor.

¹⁹ Byrne, *et al.* (2016).

²⁰ Health Workforce Australia (2013).

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