Editorial

Non-medical prescribing in Australia

***Lisa Nissen**, Associate Professor, School of Pharmacy, The University of Queensland, Brisbane, and **Greg Kyle**, Associate Professor, Discipline of Pharmacy, University of Canberra*

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The announcement in the 2009 federal budget to allow nurse practitioners and midwives access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme,[1] and the subsequent announcement of a November 2010 start date,[2] has brought non-medical prescribing into the public arena. Non-medical prescribing is not a new concept in Australia as nurse practitioners, podiatrists and optometrists have been authorised to prescribe under various state legislations for some time. However, state legislation is not uniform in relation to authorisation or formulary. Midwives are currently seeking prescribing rights,[3] and other groups such as physiotherapists and pharmacists are likely to seek them in the future.

National consistency will be an important consideration in future legislation for non-medical prescribing, including the current nurse practitioner and midwife amendments. Work is currently underway to develop national consistency around prescribing models, incorporating a focus on patient safety and access to medicines. It appears likely that Australia will adopt models similar to those in the UK,[4] focused on an overarching collaborative practice framework between medical and non-medical prescribers. Additional models incorporating limited and broad protocol prescribing are likely to be included to cover the full scope of prescribing required in Australian practice.[5] Offering a range of prescribing models will allow individual practitioners to take more responsibility for their decisions, appropriate for their skill level and qualifications, in the context in which they are practising.

Clearly, there are other key considerations regarding implementation of non-medical prescribing in Australia. These have been highlighted in position papers from the Royal Australian College of General Practitioners[6] and the Pharmaceutical Society of Australia,[7] and include issues around training and credentialing, remuneration (including access to the PBS), access to medical records and professional indemnity. A key consideration surrounds the discrepancies in state legislation for non-medical prescribing which has been highlighted by the introduction of the National Registration and Accreditation Scheme.

National registration effectively abolishes state boundaries for the regulation of health professionals, but the state boundaries remain for prescribing. This situation may encourage health professionals in border areas to move to the side of the state border where their practice has greater scope. For example, an optometrist may move their practice from Coolangatta (Queensland) to Tweed Heads (New South Wales) and be able to prescribe glaucoma drops in a collaborative arrangement with an ophthalmologist. The resultant prescription would currently need to be dispensed in New South Wales to meet state legislation. Circumstances such as these could dramatically affect patient care and access to health professionals.

Formulary definition is another area of contention. Professions with a narrow scope of practice, for example optometrists or midwives, can have a formulary relatively easily defined – similar to the dental formulary of the PBS. However, defining a formulary for professions with a broad scope of practice (for example nurse practitioners or pharmacists) would prove more difficult. Trying to define a complete formulary for such professions would be akin to trying to define a formulary for general practitioners as a professional group. Individual practitioners could have an individual formulary defined but this would be unworkable for them and importantly the dispensing pharmacists. Two possible solutions are:

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Prescribing rights are currently being extended to health professionals who are not medically qualified. While there may be benefits in having more prescribers, Lisa Nissen and Greg Kyle point out that training requirements and prescribing competencies need to be developed. Communication between prescribers will be essential and Debbie Rigby discusses how doctors and pharmacists can cooperate. There also needs to be cooperation between doctors and dentists and the letters pages show why this is important.

While there are restrictions on prescribing, there are few controls on the use of complementary medicines. Terri Foran includes them in her article on managing menopausal symptoms, while Geraldine Moses and Treasure McGuire review the potential interactions between these products and prescription drugs.

- allow the practitioner to self-define their formulary within their areas of demonstrated competence (this is the same as the UK non-medical prescribing model)
- define a range of formularies for various specialty areas, for example cardiology, respiratory, continence care, diabetes.

Training programs will need to reflect the scope of practice and whatever formulary restrictions are decided. This will be further influenced by the fact that there is currently no nationally consistent or agreed definition of what constitutes 'prescribing', or a framework of competencies, to guide what would be included in training programs and assessment. Currently, non-medical prescribers have a variety of profession-specific prescribing courses. It should be possible to develop a generic, profession-independent, prescribing course. Profession-specific modules could provide the basis of the prescribing course with the generic skill set common to all of them. This would ensure a consistent skill set across all non-medical prescribers. However, prescribing competencies would need to be developed to facilitate this process in Australia as there are currently no nationally defined prescribing competencies for any Australian prescriber, medical or non-medical.

Optometrists currently have a prescribing 'retro-fit' process that could be applied for any non-medical profession seeking prescribing rights. A 'top-up' course is available for current optometrists wanting to upgrade their qualification, and the entry level optometry course has been amended to ensure all future graduates would be automatically qualified as a prescriber. It is possible that other qualified non-medical prescribers (for example nurse practitioners) may also be required to undertake an upgrade course within a given time frame if the competency and training standards are raised above their current level. Many gaps exist in current education provision and this requires further and systematic development on a multidisciplinary basis. Profession-specific and profession-independent programs are required to generate future non-medical prescribers. These programs will be dependent on the non-medical prescribing models implemented in Australia.

Patient safety must be assured through ongoing review processes, for example as pharmacists currently do for medical prescribers. However, it is also important to allow health professionals to practise as health professionals and be personally accountable. The best prescriber for a given patient should depend on their skill set, not on which professional hat they wear.

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Letters

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Point-of-care testing

Editor, – We read Associate Professor Shephard's article with interest (Aust Prescr 2010;33:6–9), and wish to highlight emerging uses for point-of-care INR monitors in Australia. These have been trialled in various settings including:

- rural general practices[1] and community pharmacies[2], to improve warfarin safety in patients with limited access to pathology services
- patients' homes, to facilitate self-monitoring via a standardised training program[3*] and as a part of a multi-faceted post-discharge service provided by home medicines review accredited pharmacists[4*]
- within residential care facilities.[5]

These projects, conducted by the Unit for Medication Outcomes Research and Education (UMORE), have improved