



**Researched Medicines Industry
Association of New Zealand Incorporated**

Submission on Pharmacist Prescribers

July 2010

1. Introduction

This submission is from the Researched Medicines Industry Association of New Zealand (RMI). Level 8, Prime Property Towers, 86 – 90 Lambton Quay, Wellington. Contact person: Denise Wood (04) 499 4277 or dwood@rmianz.co.nz

The RMI represents prescription medicines manufacturers in New Zealand and supports a healthcare system in New Zealand that is patient-centric and focused on achieving the best health outcomes for all New Zealanders. For a list of our members please see http://www.rmianz.co.nz/about_members.php

Our members' international reputations rely on medicines being used efficiently and safely, our submission is therefore based on these two principles.

2. Context

We appreciate the opportunity to submit on this consultation.

While we support in principle pharmacists playing a greater role in providing access to medicines where such access is currently less than optimal, we are concerned that pharmacists' limited diagnostic capabilities may pose a risk to patients.

We acknowledge areas where pharmacist prescribing may be beneficial could include situations where access to primary health care may be problematic (e.g. rural services without adequate GP cover); or where pharmacist prescribing could improve the efficiency of the health system.

We acknowledge that there are a range of conditions where access to appropriate medication requires a prescription from a doctor and there would be significant benefit to patients being able to obtain these through a pharmacist as they do in some other jurisdictions of the world.

However we believe these opportunities are limited and that the current consultation does not reflect this limitation. In addition, the cost and effort of managing the risks the proposal raises may not justify the change.

3. Comments

A large portion of the benefit of the service a pharmacist provides is in “cross checking” the validity and accuracy of a doctor’s prescription. This “cross checking” is what enhances the safe use of medicines in the current system. The requirement for a second person to “cross check” a pharmacist’s prescription is likely to reduce any efficiency generated by the proposal.

The success of the proposal to allow pharmacist prescribing hinges on adequate safety systems being put in place. Although the proposal refers to “systems to ensure patient safety” (p8) it does not specify the steps needed within such systems.

The Pharmacy Council of NZ (PCNZ) states that the responsibility for developing quality monitoring and audit processes to ensure the proposal succeeds should be the duty of another agency. We believe the PCNZ should at the very least describe what processes would be feasible. In the absence of such information we believe it would be unwise to proceed with the proposal. RMI submits that audit and monitoring requirements should be developed in concert with this proposal, to avoid major stumbling blocks during implementation.

“Segregation of duties” would need to be ensured. Both patients and pharmacists need to be protected from the possibility that prescribing could be influenced by profit margins. PCNZ proposed controls to prevent this will add to expenses and are unlikely to be able to adequately control financial incentives altering prescribing practice. The controls are also likely to reduce any efficiency gains the system may generate.

The study of existing pharmacists’ involvement in selecting medicines (p 24) cannot be assumed to be representative of most pharmacists. The sample size (n = 20) is incredibly small and the additional experience and training that most respondents reported is above what may be expected from average community pharmacists.

The concept of a pharmacist “working in a collaborative health team” should be elucidated to provide a meaningful and measurable situation. The concept of the doctor and pharmacist working in concert to support the interests of the patient is indeed attractive but the ability to share all of the relevant patient information required to make a prescribing decision (e.g. consultation notes and pathology results) would require major health IT system changes that are not yet underway.

The areas identified as providing improved health outcomes and efficiencies (p27) appear to be the personal opinions of the pharmacists surveyed in the study referred to on page 24 and as such offer very limited scope for efficiencies or improved access. The examples cited are also contingent on aspects that may not be controllable, such as the quality of the professional relationship with other members of the health care team. Some of the interventions described (such as treating medicine dependence on controlled drugs) are highly specialised and pose substantial risks to patients if not approached correctly. It is unlikely that this practice could be done safely in a pharmacy setting.

It appears the PCNZ is envisaging pharmacists being able to prescribe in any disease area. RMI submits that the disease areas should be predefined and limited to those where meaningful intervention is possible without requiring a complex consultation and physical examination.

4. Training and Education

A major impediment to pharmacists being able to prescribe is the absence of a module on diagnosis of illness (p14) in their original BPharm degree. The proposal does not adequately address this deficiency in training. While the educational specifications do include some information on diagnosis of the conditions being treated, the level and types of diagnostic interventions would need to be defined by the likely areas of prescribing envisaged (i.e. for which diseases prescriptions would be written).

Although the “Comprehensive Pharmaceutical Care” model of providing pharmaceutical services is referred to, it appears that this is currently available only as an academic thesis and is therefore not generally accessible.

The consultation document has not identified why any pharmacist would choose to do a post graduate diploma and acquire prescribing rights. If the objective is to improve subsequent income levels, we believe future earning potential should be described. This also raises questions about how pharmacists might hope to generate more income; for example: by improved service provision and patient loyalty; increased turnover from medicines dispensed; higher salary in hospital pharmacy practice; or charging a fee for the consultation and diagnostic service provided.

These situations may either increase or reduce the likelihood of prescribing habits being unduly influenced by profit margins on medicines. In the interests of transparency RMI believes the PCNZ should clarify the likely reimbursement model.

We would support pharmacists being given prescribing rights, subject to their obtaining a post graduate diploma. We note that the Pharmacy Schools in Auckland and Otago have well established links within the medical faculties, which will enable them to refine the requirements for this diploma.

5. Conclusion

The RMI supports a health system that places the patient at the centre and where reform significantly improves the environment for the patient in a safe and efficient manner.

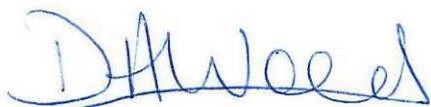
While we support in principle pharmacists playing a greater role in providing access to medicines where such access is currently less than optimal, we are concerned that pharmacists' limited diagnostic capabilities may pose a risk to patients.

The success of the proposal to allow pharmacist prescribing hinges on adequate safety systems being put in place. In addition, the success of the proposal requires that the doctor and pharmacist are working in concert to support the needs of the patient and the IT systems required to support this are not yet available.

RMI submits that audit and monitoring requirements should be developed in concert with this proposal, to avoid major stumbling blocks during implementation.

RMI submits that the disease areas should be predefined and limited to those where meaningful intervention is possible without requiring a complex consultation and physical examination.

Both patients and pharmacists need to be protected from the possibility that prescribing could be influenced by profit margins. RMI believes PCNZ proposed controls to prevent this will add to expenses and are unlikely to be able to adequately control financial incentives altering prescribing practice.



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6 July 2010