Pharmacist Prescribing

POSITION STATEMENT

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE POSITION

ACRRM acknowledges and values the important role that pharmacists play in the healthcare system.

The College does not support an extension to the current scope of pharmacist practice, including to current pharmacist prescribing protocols.

Any extension of the existing prescribing protocols has the potential to compromise the provision of safe, high-quality continuity of care especially for people in rural and remote communities.

Good policy should support and strengthen primary care-based service models

Rural and remote communities deserve equitable access to excellent healthcare. The College contends that the highest value care will extend from a model founded on continuous, holistic care by a locally-based primary-care clinician. These doctors can deliver and lead coordination of care in partnership with the local healthcare team (including pharmacists) and collaborate with remote and visiting consultant specialists as required.

It is widely evidenced that health systems based on a strong primary healthcare foundation are the most effective and efficient in terms of cost and health outcomes[1] including reduction in preventable hospital admissions[2] and that continuity of patient care leads to better mortality outcomes.[3]

Policies which separate patients' regular doctor from their ongoing medication regime will compromise continuity of care; inhibit preventative healthcare; and increase patient risk.

Each patient interaction with their practitioner presents an opportunity to review and discuss their ongoing holistic care and identify any important changes to their overall health. Each incremental new policy to replace these opportunities further erodes the effectiveness and continuity of care.

There is clear evidence that continuity of care improves patient outcomes[4] and conversely, that patient mortality has significantly increased where patients have repeatedly missed general practitioner appointments.[5]

Dependence on prescribed medications is a growing national problem with a 168 percent rise in pharmaceutical drug deaths recorded over the past 10 years.[6] Decreasing the role of the clinician in managing the patient's ongoing care while increasing the role of the dispenser who is also the retailer is likely to exacerbate this problem. The patient's regular medical practitioner is best positioned to provide whole-of-patient care and ensure that prescribing is appropriate.

Antimicrobial resistance is a growing global issue and any diminishing of the role of the patient's regular doctor in actively managing their care will reduce their effectiveness in supervising and discouraging antibiotic use in favour of non-pharmaceutical solutions.

Extending the role of pharmacists as prescribers in rural towns will not improve health outcomes and may jeopardise access to a wider range of health care services in the longer term.

Access to appropriate care is a critical issue for patient health and well-being especially in rural and remote locations, where people generally have a poorer overall health status than their urban counterparts.

Rural Generalist practitioners are best positioned to deliver cradle-to-grave care for patients and their families. They also provide a range of other services, including hospital, after-hours and emergency care; community and public health; aged care and palliative care.

In order to maintain these services within the community, the local rural medical practice must be viable and sustainable. Any measures which erode the scope of practice of medical practitioners or detract from the overall value proposition of rural medical practice will potentially jeopardise access not only to general-practice based primary care, but also to the other services that these doctors provide.

There is no evidence to suggest that expanding the scope of practice of pharmacists will improve access to healthcare services in rural and remote communities. In the majority of cases, there are no pharmacies located in communities which do not already have a general practice or other access to primary health care services, and it is highly unlikely that a pharmacy would be a viable business proposition in those areas.

Pharmacist prescribing could only improve costs and access for patients where national standards with respect to patient safety and quality care have been conceded.

The College does not accept the premise that pharmacists would be able to provide high-quality prescribing services at a lower cost and with shorter waiting times than doctors. Disparities in the service costs and availability of the two professions reflect the much higher compliance regimes embedded in medical practice. National quality and safety regulators have deemed these the minimum acceptable standards for provision of medical services. These include extensive requirements for training, continuing professional development and ongoing skills credentialing and certification; professional liability cover; and the regulatory requirements for accreditation for medical surgeries.

Should pharmacists be subjected to these same professional compliance levels they could be expected to move to similar cost and time structures.

Suggestions have been made that health consumer convenience in terms of waiting times and costs will be improved by combining the role of retailing and dispensing of drugs with the role of prescribing drugs and removing meaningful patient interaction with their doctor. Such claims discount the fact that any such patient convenience would be achieved at the expense of patient care, resulting in poorer health outcomes and increased costs to both the individual and national health care budget.

Policy enabling pharmacist prescribing of repeat prescriptions targets patients with the highest and most complex care needs, such as the aged and people with continuing and complex conditions and directs them toward low value care.

There is growing health sector demand for aged care and the care of people with chronic and complex conditions. These people represent a high-needs health consumer group that should appropriately be targeted for the best possible medical attention and for whom ongoing healthcare monitoring and continuity of care is most important.

For example, for people with chronic mental health conditions, missing more than two general practitioner appointments was linked to an 8-fold increase in all-cause mortality.[7] These are the consumer group most vulnerable to the temptation to use pharmacist prescribers and forego important medical appointments which facilitate coordinated and holistic care and provide an optimal and multi-faceted treatment regime.

The College considers that facilitating issuing of repeat prescriptions by pharmacists and any other initiative which seeks to cut costs by discouraging these people from interface with their doctor is regressive policy, diminishing healthcare for those most needing it.

There is a fundamental distinction in the value proposition for policies enabling vaccination by pharmacists and those enabling pharmacists to prescribe repeat medications. Vaccination programs have an overriding imperative to achieve mass uptake while the primary focus for prescribing ongoing medications must be on delivering high-quality, continuous medical care.

Find out more

If you have any queries relating to this Position Statement, please contact us by:

Email: policy@acrrm.org.au
Phone: 1800 223 226
Website: mycollege.acrrm.org.au/contact-us

Endnotes

1 Ibid, Starfield B, Shi L (2002).

2 Australian Institute of Health and Welfare (2018). Transition between hospital and community care for patients with coronary heart disease: New South Wales and Victoria, 2012–2015. AIHW Cat. no. CDK 9

3 Pereira Gray D, et al (2017) Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8:e021161.

4 Pereira Gray D, et al (2017) Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8:e021161

5 McQueenie R, Ellis D, et al. (2019) Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Medicine. 17:2

6 AIHW (2018). Non-medical use of pharmaceuticals: trends, harms and treatment 2006–07 to 2015–16. AIHW Cat. No. HSE195

7 Ibid. McQueenie R, Ellis D, et al. (2019)

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live, and pay respect to their elders past present and future.