

SUBMISSION TO THE OPTOMETRY BOARD OF AUSTRALIA

**PROPOSAL FOR THERAPEUTIC QUALIFICATION TO BE A REQUIREMENT FOR
GENERAL REGISTRATION OF OPTOMETRISTS**

PURPOSE

1. The Pharmaceutical Society of Australia (PSA) makes this submission to the Optometry Board of Australia (OBA) on a proposal that therapeutic qualification be a requirement for general registration of optometrists in Australia.

BACKGROUND

2. PSA is the peak professional organisation representing some 75 per cent of pharmacists across Australia. PSA's core functions are: supporting pharmacists' commitment to high standards of patient care; providing continuing professional development, education and practice support to pharmacists in all sectors of professional practice; and representing pharmacists' role as frontline health professionals.

PSA'S VIEWS ON THE PROPOSED CHANGES

3. **Standards of practice.** PSA supports clear and consistent requirements in competency and training for optometrists which:

- a. focus on patient safety and quality services;
- b. provide equitable access to optometric services for consumers; and
- c. meet consumer expectations of optometric practice.

4. PSA understands that the training currently necessary for therapeutic endorsement has now been incorporated into existing optometry courses. PSA supports the application of these requirements to all existing and future optometrists.

5. **Transition process.** The consultation document states that currently, approximately 800 of Australia's 4,000-plus optometrists have their registration endorsed for scheduled medicines. In order to implement the changes proposed in the consultation document, this would equate to over 80 per cent of the profession requiring up-skilling with an appropriate therapeutic qualification in less than three years.

6. PSA would suggest that for the transition to be efficient and effective, a realistic implementation timeline and processes would be required. Further, we would request transparency in the transition process for consumers and health professionals.

7. **Overseas-trained optometrists.** The consultation paper states 'consistency in registration arrangements' as one of the reasons for seeking therapeutic qualification to be a general registration requirement for optometrists. It would seem logical therefore that overseas-trained optometrists should be required to complete appropriate competency assessments for therapeutic practice unless the person has successfully completed a program of study that is considered to be substantially equivalent to an OBA-approved program of study.

8. **Registration for practitioners in non-clinical roles.** The Pharmacy Board of Australia (PBA) states that the practice of a health professional should not be restricted to the provision of direct clinical care. PSA agrees with the PBA's definition of 'practice' which

is that the individual uses their skills and knowledge in their profession and that it includes working in a direct non-clinical relationship with clients; working in management, administration, education, research, advisory, regulatory or policy development roles; and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

9. Based on the above, if therapeutic qualifications become part of the general registration requirements for optometrists, PSA believes they should apply to all practising optometrists regardless of their role. We also believe this would be necessary if there is to be 'consistency in registration arrangements' as stated in the consultation paper.

SUMMARY

10. PSA supports a timely and transparent transition process for the implementation of new general registration requirements for optometrists in Australia which focuses on patient safety and quality, consistent standards and equitable access to services for consumers.

11. PSA's document entitled *Principles for a national framework for prescribing by non-medical health professionals* (Attachment 1) has been provided with this submission for the optometry profession's interest. As outlined in that document, PSA believes common and consistent principles underpinning prescribing by non-medical health professionals can facilitate a more efficient and effective health system.

12. PSA has worked in partnership with Optometrists Association Australia on issues of mutual interest (eg. rescheduling of chloramphenicol for ophthalmic use). PSA would welcome further partnership opportunities with organisations within the optometry profession where the expertise of pharmacists on medication management and the quality use of medicines may be valuable.

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4 March 2011

Attachment:

1. Pharmaceutical Society of Australia. Principles for a national framework for prescribing by non-medical health professionals. March 2010.

PRINCIPLES FOR A NATIONAL FRAMEWORK FOR PRESCRIBING BY NON-MEDICAL HEALTH PROFESSIONALS

PURPOSE AND SCOPE OF THIS DOCUMENT

1. The Pharmaceutical Society of Australia (PSA) presents its views on principles which should underpin the development and establishment of a national framework for prescribing by non-medical health professionals.
2. PSA seeks the support of governments and health professionals for the establishment of a national framework for prescribing by non-medical health professionals.
3. It is neither feasible nor appropriate for this paper to canvass all of the issues relevant to this topic. PSA believes input on a range of issues from each health professional group will be required to determine and articulate the details relevant to each profession but also in the context of the broader health care environment. Examples of issues requiring separate consideration include:
 - legislative framework;
 - registration (initial and ongoing) requirements to cover prescribing activities;
 - continuing professional development requirements;
 - professional indemnity insurance;
 - remuneration (eg. funding source, access to Pharmaceutical Benefits Scheme prescribing);
 - practice implementation issues (eg. record keeping, multidisciplinary communication and referral mechanisms);
 - practice support (eg. mentoring, peer support); and
 - quality assurance and evaluation.

DEFINITION

4. For the purpose of this document the term 'prescribing' may include the selection and initiation of pharmacotherapy (with a prescription or non-prescription medicine) for a person and clinical management of that person including follow-up and continuation, modification or discontinuation of pharmacotherapy.
5. Activities such as the over-the-counter provision of non-prescription medicines and repeat prescribing (limited supply of medication to continue treatment until the next appointment with a medical practitioner) are excluded from this framework.
6. In this paper, the term 'consumer' means "a potential user of health products and services" and 'patient' means "a person in receipt of medical and/or therapeutic services or advice".¹

¹ Pharmaceutical Society of Australia. Competency standards for pharmacists in Australia 2003. Canberra: PSA; 2003.

BACKGROUND

7. The use of medicines in Australia is a significant health care intervention for both prevention and treatment of disease.

- Although GPs are now issuing fewer prescriptions (with 11 fewer prescriptions being written on average for every 100 GP-patient encounters in 2007–08 than 10 years earlier), more than 80% of GP consultations still involve a medicine being prescribed.²
- In 2006–07, the second most common reason for patients consulting a GP was “the need for medication or repeat prescriptions”.³
- Requests for prescriptions have risen 40% between 1998–99 and 2006–07.³
- The total expenditure on prescription and non-prescription medicines (including some non-durable medical products) in 2006–07 reached \$12 billion.⁴

8. With these levels of investment by governments and consumers, delivering the best possible outcomes by focusing on prescribing activities by health professionals and achieving optimal use of medicines must be a high priority.

9. Safe and appropriate use of medicines can deliver positive benefits for consumers. PSA and the pharmacy profession strongly support the National Medicines Policy⁵ (NMP) and recognise the primacy of consumers and the need for a partnership approach as key elements for achieving quality use of medicines⁶ (QUM) for all Australians.

10. PSA believes the goal of prescribing by non-medical health professionals should be to provide safe, cost effective and judicious access to medicines for consumers.

MODELS OF PRESCRIBING

11. A number of models for prescribing by non-medical health professionals has been canvassed and/or adopted in Australia and internationally.

12. Different models for prescribing by non-medical health professionals can be categorised in a number of ways. These might include:

- health professional partnership arrangements (eg. dependent, supplementary or collaborative prescribing);
- level of responsibility (eg. independent vs. dependent prescribing);
- restrictions imposed by pre-agreed protocols or formularies (eg. patient group direction) or other criteria (eg. crisis management, or seasonal prescribing rights granted through the medicine scheduling system – oseltamivir in New Zealand); or
- funding source.

² Britt H, Miller GC, Charles J, Henderson J, Bayram C, Harrison C, Valenti L, Fahridin S, Pan Y, O'Halloran J. General practice activity in Australia 2007–08. General practice series no. 22. Cat. no. GEP 22. Canberra: AIHW; 2008.

³ Australian Institute of Health and Welfare. Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW; 2008.

⁴ Australian Institute of Health and Welfare. Health expenditure Australia 2006–07. Health and welfare expenditure series no. 35. Cat. no. HWE 42. Canberra: AIHW; 2008.

⁵ Australian Government Department of Health and Ageing. National Medicines Policy 2000. Canberra: AGDHA; 1999.

⁶ More information on the QUM principles can be found at: www.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm

13. It is beyond the scope of this paper to describe all models in detail. An overview of eight models of pharmacist prescribing identified from the USA, UK, Canada and New Zealand has been published and is briefly summarised at Annex A.

14. It is important to be clear that the Pharmacy Guild of Australia's 'medication continuance' proposal^{7,8} is not a pharmacist prescribing model. The intended aim of the proposal appears to be to allow a pharmacist to issue one 'standard' supply (only) where a patient has been on a particular (selected) chronic therapy medication and is unable to present a repeat. It therefore enables the patient to continue therapy.

BENEFITS OF A MULTIDISCIPLINARY APPROACH

15. The contribution of non-medical health practitioners is being increasingly valued by consumers. The average health service utilisation rate per day reported in 2008 was 270,000 consultations with a GP and 150,000 with an allied health professional.⁹

16. Since July 2004, selected allied health services have been funded by the Australian Government under Medicare, for example, the items available for people with chronic conditions and complex care needs who are being managed by a medical practitioner under an Enhanced Primary Care multidisciplinary care plan.¹⁰ This model preserves the primary role of the GP and allows for the formal integration of allied health professionals in the care of patients with appropriate funding.

17. PSA strongly advocates for the pharmacy profession to be a part of effective solutions to address the increasing demands on the health care system as a result of an ageing population and increasing prevalence and burden of chronic disease. Pharmacists and other health professionals are actively seeking to redefine their professional roles and responsibilities by ensuring their knowledge and skills are utilised effectively to help deliver timely and optimal care to all Australians.

18. PSA supports a consumer-focused, multidisciplinary team approach to health care delivery which provides consumers with access to the expertise of health professionals in a targeted manner and in a team environment to promote synergies and holistic care. PSA believes such models are cost-effective for government, deliver optimal outcomes for consumers and are professionally valuable for practitioners.

19. PSA believes prescribing by non-medical health professionals will integrate well into a multidisciplinary care model, for example through 'collaborative prescribing'. With this approach, once a diagnosis has been established by a medical practitioner or a treatment plan prepared for an individual patient, part of the responsibility for management and some activities associated with ongoing prescribing are undertaken by a non-medical health professional based on patient responses and outcomes. It has been suggested¹¹ that this model could, in particular, be applied to disease states such as asthma, diabetes, hypertension, dyslipidaemia, hypothyroidism, heart failure and thromboembolic disorders requiring anticoagulation therapy.

20. By having practitioners with different health expertise working closely together, it is likely that patient outcomes can be more closely monitored and any adverse or unintended

⁷ ABC1. National Press Club address by Kos Sclavos, National President, The Pharmacy Guild of Australia [transcript]. 23 Jul 2008.

⁸ The Pharmacy Guild of Australia. Pharmacists ready to step up [media release]. 23 Jul 2008.

⁹ Australian Institute of Health and Welfare. Annual report 2007–08. Cat. no. AUS 108. Canberra: AIHW; 2008.

¹⁰ Note that pharmacists are not eligible allied health professionals at present. For more information see: www.health.gov.au/internet/main/publishing.nsf/Content/Allied+Health+and+Dental+Care+initiative

¹¹ Pharmaceutical Council of Western Australia, unpublished submission to the Western Australian Government, 2004.

outcomes can be attended to and modified. This is of particular relevance to a patient's pharmacotherapy where early identification of medication-related issues and appropriate modification is more likely to contribute to better health outcomes for the patient and cost savings to government through reduced adverse drug-related hospital admissions and enhanced continuity of care.

21. The application of pharmacists' unique knowledge of the range of available medicines, the rationale and evidence-base behind their use, and the costs to the consumer and the health system will facilitate cost-effective use of subsidised (and non-subsidised) pharmaceuticals through more appropriate use and less wastage.

22. PSA also believes the involvement of other health professionals in this manner is likely to make a positive contribution to participation, innovation and productivity of the health workforce and provide synergies to patient care.

A NATIONAL FRAMEWORK FOR PRESCRIBING BY NON-MEDICAL HEALTH PROFESSIONALS

23. As referred to above, some non-medical health professions have already been granted prescribing rights. In most cases the process has largely been driven by each health professional group and implemented on an *ad hoc* basis without the opportunity to consider uniformity, common goals and core principles across all health professions.

24. PSA believes it is time for governments and health professionals to formally consider prescribing by non-medical health professionals as an initiative to help facilitate a more efficient and effective health system.

25. As a first step to the establishment of a national framework for prescribing by non-medical health professionals, PSA believes it is useful to develop and agree to a set of principles that all health professions (including the medical profession), governments and consumers can commit to.

26. PSA believes a national framework for prescribing by non-medical health professionals must be founded on the eight principles presented below.

Principle 1: Patient safety and access to high-quality care is of paramount importance.

27. Access and safety are two of the key rights of patients as described in the Australian Charter of Healthcare Rights.¹² Patients will expect health professionals to deliver safe and high-quality care every time they interact with the health system.

Principle 2: Prescribing rights will be granted in a way that will help enhance timely access to medicines and be safe and cost-effective for the consumer.

28. One of the central objectives of the NMP¹¹ is timely access to medicines. PSA believes prescribing rights should be granted or extended to qualified and competent health professionals in a way that will support and enhance the timeliness of access to medicines by Australians.

29. Careful consideration will be required in determining the appropriate scope of practice (in relation to activities associated with prescribing) for each profession and the likely benefit to consumers and the health care system.

¹² Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. Canberra: ACSQHC; 2008.

Principle 3: Health professionals must have an understanding of and a commitment to the principles of QUM.

30. Pharmacy practice in Australia across all sectors is strongly underpinned by QUM⁶ principles.

31. It is PSA's firm belief that any health professional undertaking prescribing activities must have a strong grounding in and a commitment to QUM principles.

Principle 4: Prescribing and dispensing functions should be clearly delineated.

32. PSA represents the core group of health professionals engaged in dispensing medicines. PSA strongly supports a clear separation* of the two related functions of prescribing (ordering) and dispensing (supply) to ensure the promotion of highest safety standards.

33. PSA believes the framework should also address concerns about perceived and potential conflicts of interest and to minimise, if not remove, the potential for supplier-induced demand.

Principle 5: Priority will be given to clarify and agree all interprofessional issues which will impact on continuity of care for the patient.

34. PSA believes a successful outcome from multidisciplinary care will depend on each health professional accepting a shared responsibility for patient care and committing to engaging in interprofessional communication of the highest standard.

35. PSA recognises that many issues (eg. access to health and medical records held by other practitioners, mechanisms for interprofessional communication and reporting) can only be clarified and agreed with the highest level of commitment by all stakeholders. It is vital that agreement is reached on all of these issues so that activities linked to prescribing by non-medical health professionals do not impact negatively on the continuity of care for patients.

Principle 6: Prescribing as an activity should complement and value-add to the spectrum of other core services provided by that health profession.

36. It could be argued that any health professional who has demonstrated appropriate competencies can undertake prescribing in any context. However, PSA believes that the framework should at least initially be built on the premise that the scope of prescribing allowed by a non-medical health professional will be complementary to existing core services undertaken by that group of health professionals.

Principle 7: A credentialing process should be implemented to ensure practitioners possess the appropriate competencies.

37. Credentialing is a key step to demonstrate a health professional possesses the appropriate knowledge and experience and is deemed to be qualified to be granted certain privileges.

38. Implementing a credentialing process for each health profession will promote rigour and confidence in the framework and will also act as a risk management tool. Further, a regular

* It is PSA's firm view that the separation of the two activities, prescribing and dispensing, must be clear and unambiguous. The respective health practitioners involved in undertaking the two discrete activities must be devoid of: (1) any professional, business or contractual arrangements, (2) inducements or any other forms of pecuniary interest, or (3) any other relationship where one party may perceive to or actually benefit directly from the professional decision-making process, health service activity or business of the other party.

re-credentialing process should be implemented to ensure maintenance of competency by practitioners.

Principle 8: Outcomes of any trials or pilot programs on prescribing by non-medical health professionals will be used, if appropriate, to inform the framework.

39. PSA is aware of a number of trials currently in progress, particularly those involving pharmacists with a role in prescribing activities.

40. PSA believes the outcomes of such studies may help to inform and refine elements of a national framework. These may relate to, for example, best practice protocols for the prescribing of certain classes of medicines by non-medical health professionals, or optimal partnership arrangements for certain health care settings.

41. PSA believes the establishment and ongoing development of a national framework must be receptive to recommendations from trials and pilot programs.

42. The eight principles outlined in this document are fundamental to ensuring patient safety and timely access to medicines, and to promoting the quality use of medicines. These should therefore underpin any model of prescribing by non-medical health professionals. PSA believes it is vital that these principles are further articulated through a partnership between all health professionals, governments and consumers.

SUMMARY

43. PSA strongly supports the establishment of a national framework for prescribing by non-medical health professionals and seeks the support and commitment of government and all health professionals to progress this initiative.

44. PSA believes such a framework must be focused on consumers and be underpinned by core principles including:

- a primary concern for the delivery of safe and high-quality care;
- enhancing timely access to medicines and maintaining continuity of care; and
- promoting the quality use of medicines.

45. PSA believes proper integration of prescribing by non-medical health professionals through an agreed national framework can help enhance the efficiency and effectiveness of the Australian health system, provide benefits to government and better health outcomes to consumers.

Endorsed by:
PSA Board
March 2010

Scheduled for review:
March 2014

MODELS OF PHARMACIST PRESCRIBING¹³

1. **Independent prescribing** involves the licensed prescriber having sole and full responsibility for patient assessment, diagnosis and clinical management.
2. **Dependent prescribing** places restrictions on prescribing activities and involves the delegation of authority from an independent prescriber, usually a medical practitioner. Prescribing **by protocol** is the most common form of dependent prescribing. An agreed protocol describes the activities which the pharmacist (dependent prescriber) may perform and may list, for example, the types of diseases or drug categories covered, and the procedure, decision criteria or plan that must be followed.
3. **Dependent prescribing by Patient Group Direction (PGD)** is a model used by health authorities in the United Kingdom. A PGD involves a written direction outlining parameters (eg. dose form, dosage, quantity, frequency and period of administration, allowed circumstances for supply, further advice, follow-up) for the supply and administration of a specific prescription medicine.
4. **Dependent prescribing by formulary** is similar to, but less explicit than, prescribing by protocol. The formulary contains a limited list of prescription and non-prescription medicines, treatable symptoms, length of treatment and criteria for referrals.
5. **Dependent prescribing by patient referral** typically involves a patient being referred to the pharmacist (dependent prescriber) by a medical practitioner for the management of specific drug therapy or to achieve a specific therapeutic outcome.
6. **Dependent prescribing through repeat prescribing** has generally been used to provide a limited supply of medication to patients who have exhausted their supply prior to their next medical appointment.
7. **Supplementary prescribing** is a dependent prescribing model involving a voluntary partnership between an independent prescriber and a supplementary prescriber through which an agreed patient-specific clinical management plan is implemented with the patient's agreement. The partnership is not limited to one-on-one and can involve a team of health professionals.
8. Many studies (including some informal) have been undertaken to explore **collaborative prescribing** models between a medical practitioner and a pharmacist. The model involves the medical practitioner diagnosing and making the initial treatment decision for the patient. The pharmacist then selects, initiates, monitors, modifies and continues or discontinues pharmacotherapy as appropriate to achieve the agreed patient outcomes. The two health professionals share the risk and responsibility for the patient outcomes.

¹³ Emmerton L, Marriott J, Bessell T, Nissen L, Dean L. Pharmacists and prescribing rights: review of international developments. *J Pharm Pharmaceut Sci* 2005;8(2):217–25