Pharmacy Board of Australia

Discussion paper

4 March 2019

You are invited to provide feedback on this discussion paper

Pharmacist prescribing

Please provide feedback in a Microsoft Word file (or equivalent)[1] to PharmBAfeedback@ahpra.gov.au by close of business on Monday 15 April 2019.

Public consultation

The Pharmacy Board of Australia (the Board) is releasing a discussion paper on pharmacist prescribing. You are invited to provide feedback to the questions in the discussion paper by close of business on Monday 15 April 2019. A template Microsoft Word file for your feedback has been provided for your convenience.

The Pharmacy Board of Australia is the regulator of pharmacists in Australia and acts to protect the public by ensuring that suitably qualified and competent pharmacists are registered. The Board is responsible for developing registration standards, codes and guidelines for pharmacists and managing notifications (complaints and concerns) about pharmacists and pharmacy students.

The Board does this through its powers under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), and the National Registration and Accreditation Scheme (the National Scheme), supported by the Australian Health Practitioner Regulation Agency (AHPRA). The Board's work in regulating Australia's pharmacists in the public interest is underpinned by regulatory principles, which encourage a responsive, risk-based approach to regulation.

How your submission will be treated

Submissions will generally be published unless you request otherwise. The Board publishes submissions on its website to encourage discussion and inform the community and other stakeholders. However, the Board keeps the right not to publish submissions at its discretion, and will not place on its website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the consultation.

Before publication, the Board may remove personally-identifying information from submissions, including contact details. The views expressed in the submissions are those of the individuals or organisations who submit them, and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board also accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence.

Please let the Board know if you do not want your submission published or want all or part of it treated as confidential.

[1] You are asked to make your submission through a Microsoft Word file or equivalent. We generally publish submissions unless requested otherwise. Providing submissions in this format helps us to meet international website accessibility guidelines. However, you are welcome to provide an additional PDF version of your submission if this is your preference. More information about this is available at www.ahpra.gov.au/About-AHPRA/Accessibility.

Contents

Introduction

Health service reform is driven by the need to improve access to healthcare, including medicines, increase patient choice and to mitigate ongoing rural and remote workforce shortages.[1] Health costs associated with the ageing population and the increased burden of chronic disease are also driving reform.[2,3] An objective of our *National Medicines Policy* is that all Australian communities receive equitable and timely access to healthcare including medicines.[4] These objectives are aligned with the National Scheme.[5] The aims of the National Scheme include facilitating workforce mobility across Australia, and enabling the continuous development of a flexible, responsive and sustainable Australian health workforce.[5] Non-medical prescribing can help in achieving these healthcare goals in the Australian context.

The National Health Workforce Planning and Research Collaboration stated that the number of Australian prescribers needs to increase to maintain the current access to medicines.[2] Planning for future healthcare needs will therefore require all health practitioners to use their skill and training to the fullest possible extent, and to enable this, a redistribution of tasks will be needed.[5,6,7,8] As there are documented shortages in many areas across Australia of medical practitioners as well as other health practitioners with prescribing rights[6], expanded prescribing rights to other health practitioners is an important strategy.[8]

The public need for improving medicines management

Non-medical prescribing may contribute to the delivery of sustainable, responsive and affordable access to medicines.[1,2,4] It may reduce costs, increase access, and improve outcomes for patients without compromising safety and quality.[4,9] It promotes a flexible workforce, which is an important initiative to ensure consistency of healthcare delivery as the Australian population ages.[2,4] A well-trained pharmacist workforce with expertise in medicines management with the ability to prescribe has the potential to facilitate safe and improved access to medicines for all Australians.[9,10,11,12]

Background

Health Profession Prescribing Pathway

Non-medical prescribing is part of the strategy to reform healthcare in Australia and internationally.[6] The *NPS Prescribing Competencies Framework 2012* and the *Health Professionals Prescribing Pathway 2013* (HPPP) both define prescribing as 'an iterative process involving the steps of information gathering, clinical decision-making, communication, and evaluation that results in the initiation, continuation or cessation of a medicine.'[7,8] In Australia, non-medical prescribing has been successfully extended to dentists, nurse practitioners, midwives, podiatrists and optometrists applying different prescribing models.[7] Appendix A outlines the current state and territory legislation for health professionals to prescribe medicines. Non-medical prescribing can result in improved access to medicines for communities, promote workforce flexibility and contribute to cost-effective care. Non-medical prescribing has demonstrated to be safe in international settings.[2,5,6,9]

The HPPP proposed three models of non-medical prescribing:

- Prescribing under a structured prescribing arrangement.
- Prescribing under supervision.
- Autonomous prescribing.

In each circumstance, the prescriber must recognise, and prescribe according to their competence for their scope of practice, in accordance with legislative authorisation and with a collaborative approach to patient care. These models of prescribing are further explored in the discussion section of this paper.

International prescribing models

Pharmacist prescribing has become an accepted part of the scope of practice of pharmacists in other comparable developed countries including New Zealand and the United Kingdom, and some provinces and territories in Canada. These countries apply differing prescribing models, education and training standards as well as registration requirements.[13,14,15,16,17,18,19]

In Canada, the prescribing authority, the model, education and training requirements and continuing professional development requirements vary between the provinces and territories.[17,18,19] The Canadian province of Alberta has implemented a model that correlates to the autonomous prescribing model in the HPPP. All pharmacists on the clinical register in Alberta may prescribe most medications with the exception of controlled drugs (equivalent to the Australian Schedule 8 medicines such as opiates) and benzodiazepines by adapting a prescription or may prescribe in an emergency.[20] Pharmacists who have been granted an additional prescribing authorisation may also prescribe to initiate drug therapy and/or manage ongoing drug therapy.[20] The variation in pharmacist prescribing models across the different provinces in Canada has the potential to lead to confusion in the area of pharmacist prescribing.

In the United Kingdom, two models of pharmacist prescribing are used, supplementary prescribing (structured) and independent prescribing (autonomous). Pharmacists with rights to undertake structured prescribing may carry out further training to prescribe autonomously.[21]

Current situation in Australia

In Australia, a number of health professions have prescribing rights. Medical practitioners, dentists, nurse practitioners, midwives, pharmacists, optometrists and podiatrists can prescribe within their scope of practice. Pharmacists are authorised under state and territory drugs and poisons legislation to supply Schedule 2 and Schedule 3 medicines.

Pharmacists can authorise the supply of Schedule 4 medicines without a prescription in limited situations.

- The emergency supply provisions in most state and territory laws allow for a three-day supply with restrictions.[22]
- The continued dispensing arrangement allows supply of a single full pack of specified medicines (the oral contraceptive pill and statins) as a Pharmaceutical Benefits Scheme benefit without a prescription once in a 12-month period.[23]

Both continued dispensing and emergency supply require information gathering, clinical decision-making and communication, with the person requested to return to the prescriber for monitoring and review for ongoing supply.

Several initiatives or trials have or are currently being carried out around pharmacist prescribing. Two of these initiatives are described below.

> A current Victorian government initiative aims to manage medicines for chronic conditions in a collaborative care arrangement between general practitioners and pharmacists. In this initiative, the general practitioner leads patient care in collaboration with the pharmacist who undertakes regular monitoring and dose adjustments of the medicines. The patient is assessed by the general practitioner who writes an agreed management plan including monitoring requirements and dosage adjustments. The pharmacist receives a copy of the management plan. The patient attends the pharmacy for the specified monitoring and medicine supply. The pharmacist can adjust medicine doses as specified in the management plan, and when necessary the pharmacist refers the patient back to the general practitioner. **[24]**
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> A partnered pharmacist charting process was implemented at The Alfred Hospital, Melbourne, in the General Medicine Unit and Emergency Short Stay Unit in 2012 as an alternative to medical prescribing.[25] The process involves medicine review and subsequent medicine charting on patient admission. It is a partnership between a pharmacist who is credentialed in the workplace and a medical practitioner. The pharmacist and the admitting medical practitioner have a face-to-face discussion about current medical and medicine-related problems, and develop a shared medicines management plan. Appropriate medicines are then charted by the pharmacist on the inpatient medication chart from which nurses administer the medicines. The pharmacist and the treating nurse then discuss the medicines management plan, including any urgent medicines to be administered, drug-related monitoring and reasons for any medicines changes. An expanded evaluation of the model was carried out in 2017 in general medical units in seven public hospitals in Victoria.

On 26 June 2018, the Board held a Pharmacist Prescribing Forum. The day-long forum was an opportunity to explore, identify and articulate the roles of different stakeholders to successfully develop proposals about pharmacist prescribing of Schedule 4 and Schedule 8 medicines that could be

implemented and sustained as part of a broader range of health services to effectively meet the health needs of the community.

Before the forum, participants considered a briefing paper summarising the current national and international literature on non-medical prescribing. Presentations on the day provided participants with an overview of work completed previously to underpin the development of the HPPP and the *NPS Prescribing Competencies Framework 2012*, an overview of pharmacist prescribing models currently in place internationally and lessons from the nursing and midwifery profession's journey of prescribing.

Through a series of structured workshops, participants also explored the public need for pharmacists prescribing, education and training requirements, legislative considerations and stakeholder engagement. The briefing paper can be viewed on the Board's website.

Stakeholders at the forum included hospital and community pharmacists, government health department representatives, professional association delegates, state and territory pharmacy authorities, consumer representatives, education providers, the Australian Pharmacy Council (APC), New Zealand government advisers, pharmacists with firsthand experience as prescribers overseas, Board members and AHPRA staff. A full list of forum attendees is in the forum report which can be viewed on the Board's website.

The outcomes of the forum identified strong support for enhancing the role of pharmacists in the quality use of medicines by expanding a pharmacist's ability to prescribe. Participants highlighted many ways in which pharmacists could enhance timely access to medicines, reduce medicines-related misadventures and improve the efficiency and cost effectiveness of the use of medicines. These actions could contribute to reducing unnecessary presentations or admissions to hospitals, reducing hospital length of stay and improved continuity of care particularly for aged care patients, for people with multiple complex conditions and for those living in rural and remote settings.

The key outcomes of the forum were:

- strong support for team-based collaborative care
- strong support for enhancing the role of pharmacists in the quality use of medicines by expanding a pharmacist's ability to prescribe
- agreement that prescribing and dispensing functions should be separated
- most participants felt that pharmacists were already well placed to undertake prescribing under a structured prescribing arrangement and prescribing under supervision and that these activities could be adequately enabled and governed through relevant jurisdictional policy and/or legislation without the need for additional regulation by the Board
- strong support for the profession to aim for pharmacists to prescribe via a structured prescribing arrangement at the point of initial registration
- strong agreement that additional education and training would be needed for autonomous prescribing by pharmacists, especially when addressing the competencies needed for diagnosis and assessment
- acknowledgment of perceived barriers to prescribing which were identified as:
    - variation in state and territory legislative requirements,
    - political processes of other health professionals, and
    - funding
- all participants agreed that there should be uniform arrangements to enable pharmacists to prescribe Schedule 4 and Schedule 8 medicines across the state and territory medicines and poisons legislation to allow workforce mobility and equivalent access to services by consumers/patients, and
- support for a pragmatic approach towards the implementation of prescribing through a structured prescribing arrangement and prescribing under supervision models first, followed by autonomous prescribing with strong support for 'collaborative or team prescribing within the scope of practice of the pharmacist'.

Discussion

As outlined in the HPPP, and emphasised by forum participants, any proposed model of pharmacist prescribing must ensure collaboration with other health practitioners involved in the patient's care.

To help the profession to establish proposals for pharmacist prescribing, the Board has developed a range of discussion questions to further explore:

- models of prescribing that can be pursued by the profession including evidence to support each proposed model, and
- any gaps in evidence identified that may need to be addressed by the profession and/or other stakeholders.

Gathering this evidence and information will clarify what role pharmacist prescribing may have in meeting a public need and identify any regulatory actions that are required to protect the public.

Possible frameworks for pharmacist prescribing in the Australian context

In exploring future models of prescribing by pharmacists, there is the opportunity to consider all three collaborative models of prescribing as proposed by the HPPP. The HPPP sets out:

- principles that health professionals who prescribe should adhere to
- steps a health professional must complete to ensure safe and competent prescribing
- safe models of prescribing, and
- roles and responsibilities.

Under the HPPP, pharmacists must complete the following steps to ensure safe and competent prescribing:

- complete the required education and training
- obtain recognition from the Board of competence to prescribe (either through primary qualification or endorsement)
- ensure authorisation to prescribe under the relevant legislation in the state or territory in which the pharmacist practises
- prescribe within scope of practice, and
- maintain and continuously develop competency to prescribe.

The HPPP notes that the individual scope of practice of a health practitioner can be influenced by the clinical settings and environment in which they practice (as well as any requirements of the employer or health service). Therefore, the clinical setting in which a pharmacist practises can influence the model of prescribing that may be safe and effective.

Models of pharmacist prescribing of Schedule 4 and Schedule 8 medicines

Although the HPPP proposes three models of prescribing, most forum participants indicated that the profession should initially proceed with prescribing under a structured prescribing arrangement and/or prescribing under supervision.

Forum participants highlighted that a proposed model of pharmacist prescribing in Australia would need to:

- meet a public need or unmet demand
- achieve cost effective outcomes
- reduce adverse effects
- improve access to medicines for the community
- ensure collaboration between the health practitioners involved in the patient's care
- ensure clear separation of prescribing and dispensing, and
- involve nationally consistent regulation and models of prescribing.

When developing a model for pharmacist prescribing, the *National Medicines Policy* and the objectives and principles of Australia's *National Strategy for Quality Use of Medicines* (QUM) must also be considered. Any proposal for an endorsement for scheduled medicines must be compatible with the *National Medicines Policy* and QUM. Regulatory processes, such as a proposal for an endorsement for scheduled medicines, must comply with the *Council of Australian Governments (COAG) best practice regulation* requirements.

The Quality Use of Medicines is structured around four main principles:

- Judicious use – ensure medicines are used only when suitable taking into consideration non-medicines when appropriate
- Appropriate use – when choosing a medicine take into consideration a number of factors such as risks and benefits, dosage, duration and cost
- Safe use – minimise misuse of medicines (overuse and underuse) and resolve medication problems such as adverse events
- Efficacious use – ensure that medicines improve health outcomes and achieve goals of therapy.

Any proposed model of pharmacist prescribing would need to demonstrate that it contributes to and supports QUM.

Prescribing under a structured prescribing arrangement

As outlined by the HPPP, this model would require enough documentation of the structured prescribing arrangement to describe the responsibilities of the prescriber(s) involved and the communication that would take place between healthcare practitioners and the person taking the medicine. The prescriber would only prescribe under a guideline, standing order or protocol.

The Board notes that this model would need an established diagnosis by an appropriately trained healthcare professional, usually a medical practitioner. Protocols would need to be developed collaboratively and define clearly the roles of each member of the team, with clear referral responsibilities and pathways.

> *Example:* A pharmacist is working in a general practice that uses a Health Care Home model. The healthcare team has decided to target optimal blood pressure control as a quality improvement exercise. Together, the general practitioners, allied health practitioners, practice nurses and practice pharmacist develop a protocol for managing blood pressure. The general practitioners identify patients to refer to the shared care arrangement. The group of patients attend regular shared consultation sessions with the dietician and physiotherapist for nonpharmacological interventions. At each session, the nurse measures their blood pressure. The pharmacist titrates the antihypertensive therapy according to the protocol to ensure blood pressure control stays within the target range. This change is updated in the clinic's medical software and in the patient's *My Health Record*. The pharmacist issues a new prescription to the patient that can later be presented at a community pharmacy to be dispensed.

Prescribing under supervision

Under this model, the HPPP describes prescribers as having limited authority to prescribe medicines within their scope of practice under the supervision of another authorised health professional. The prescriber would be aware of their role in the healthcare team, ensuring appropriate communication between team members including the person taking the medicine.

The Board notes that under this model pharmacists prescribing under supervision would implement an agreed clinical management plan that was patient-specific.

> *Example*: A community pharmacist and general practitioner discuss de-escalating the proton pump inhibitor for a patient. The patient was using a high dose proton pump inhibitor (esomeprazole 40mg daily) for gastrointestinal reflux associated with a short course of diclofenac (a nonsteroidal anti-inflammatory). The patient has now ceased the diclofenac, and no longer has any gastrointestinal reflux symptoms. The patient, general practitioner and pharmacist agree to a dose reduction schedule with dose reductions every two weeks and the pharmacist implements this agreed process.

Autonomous prescribing

The HPPP states that under this model, prescribers would prescribe within their scope of practice without the supervision or approval of another health professional. The prescriber has been educated and authorised to autonomously prescribe in a specific area of clinical practice. The prescriber would be aware of their role in the healthcare team and respect the role of other team members, ensuring appropriate communication between all team members including the person taking the medicine.

The Board notes that under this model, pharmacist prescribers would be responsible and accountable for patient assessment and clinical management decisions including prescribing.

> *Example:* A pharmacist in a hospital reviews a medication chart and observes that there are some missing therapies. The patient has been using regular opioids and is experiencing considerable nausea. No antinauseants are prescribed. The hospital pharmacist notes that this appropriate therapy has been omitted from the chart. The pharmacist prescribes an antinauseant on the medication chart and writes a note in the progress notes to explain why this has been done and when it should be reviewed.

Education and training considerations

The HPPP states that the Prescribing Competencies Framework developed by *NPS Medicinewise* is the nationally recognised standard for prescribing education of health professionals. Accredited prescribing education and training programs must be aligned with the national Prescribing Competencies Framework.

The education requirements will differ according to the proposed model of prescribing. If pharmacists are aiming to prescribe under a model at initial general registration, then undergraduate courses and intern training programs will need to ensure that pharmacists can meet the requirements outlined in the *NPS Prescribing Competencies Framework 2012* when applying for initial general registration. Appropriate education accreditation standards would need to be developed, implemented and regularly assessed.

Prescribing under a structured prescribing arrangement and prescribing under supervision

Research commissioned by the Board identified that pharmacists could meet the requirements outlined in the *NPS Prescribing Competencies Framework 2012* to prescribe under a structured prescribing arrangement and prescribe under supervision without the need to complete significant additional education and training.[11] The review, which involved mapping university curriculums to the *NPS Prescribing Competencies Framework 2012,* found that the current curriculums performed favourably in relation to the competencies for treatment options and professional practice, and identified gaps in those relating to assessment, shared decision-making, co-ordination and monitoring and reviewing.[11]

Forum participants supported the profession aiming for pharmacists to have the knowledge and skills to prescribe under a structured prescribing arrangement at initial registration. The competency mapping commissioned by the Board indicated that current programs of study may only need minor changes to support this. Forum participants agreed that a change in emphasis in the way content is delivered and assessed for particular competencies could support this model.

Responses from forum participants about the education and training requirements for pharmacists to prescribe under supervision were mixed. Over half of the forum participants felt that prescribing under supervision would not require additional experience or study but agreed that a change in content delivery would be required.

Autonomous prescribing

Forum participants mostly agreed that programs of study should not be changed to support autonomous prescribing at initial registration. The consensus at the forum was that autonomous prescribing by pharmacists would need a minimum level of clinical experience and a postgraduate qualification, including formal supervision and mentoring arrangements.

Legislative considerations

Depending on the model of prescribing, local governance arrangements may be able to establish the supporting regulatory framework. The legislation in each state and territory provides for particular health professionals to prescribe medicines. To ensure workforce mobility, it is desirable to establish nationally consistent regulatory requirements for pharmacist prescribing.

The HPPP notes that a National Board may recognise the health professional's competence to prescribe by recognition that the primary qualification of registration is enough to prescribe medicines. Prescribing can be recognised as an inherent part of the scope of practice for the health professional.

Professional practice standards would need amending to reflect the potential role of a pharmacist prescriber.

Prescribing under a structured prescribing arrangement and prescribing under supervision

As pharmacists may potentially be ready to carry out prescribing under a structured prescribing arrangement, forum participants identified that this model could be governed through relevant jurisdictional policy or legislation without the need for additional regulation by the Board. Forum participants noted that prescribing under supervision could also be governed through relevant jurisdictional policy or legislation.

If the proposed model of prescribing requires an endorsement of registration for scheduled medicines, then a registration standard for endorsement to prescribe would need to be developed, along with supporting guidelines. The registration standard would need to address:

- any requirement for post-registration clinical experience
- required skills and qualifications
- requirements for supervised practice, and
- assessment of competency to prescribe.

Autonomous prescribing

A pharmacist prescribing under the autonomous prescriber model would most likely require an endorsement of registration for scheduled medicines. Before the Board can assess and consult on the regulatory need to pursue an endorsement, extensive preparatory work is needed.

The preparatory work requires collaboration between all interested stakeholders. AHPRA's *Guide for National Boards developing submissions under the Australian Health Ministers' Advisory Council's Guidance for National Boards: Applications to the Ministerial Council for approval of endorsements in relation to scheduled medicines under section 14 of the National Law (Guide for National Boards)* describes several key considerations in the concept development stage.

Maintaining competence to prescribe

Generally, pharmacists can maintain competence within their scope of practice by meeting the Board's *Registration Standard: Continuing professional development* and *Registration Standard: Recency of practice*. If a model of prescribing requires an endorsement of registration for scheduled medicines, then endorsed practitioners may be required to complete a minimum number of continuing professional development (CPD) credits and practice hours in prescribing.

Roles and responsibilities in developing pharmacist prescribing models

The aims of this discussion paper and proposed report are:

- to facilitate and help the profession and stakeholders to explore the potential for prescribing by pharmacists
- to provide a clearer picture about model(s) of prescribing by pharmacists that are supported or not supported by stakeholders and the public, and
- to gather evidence about potential models that may be able to contribute to better health outcomes for the public and that can be successfully implemented and sustained.

The Board's primary role is protection of the public. Therefore, the model/s of prescribing that the profession may pursue will determine the level of the Board's involvement.

If a model of prescribing requires an endorsement of registration for scheduled medicines then the Board has a role in developing a submission to the Ministerial Council seeking approval to endorse pharmacists under section 94 of the National Law. The Board would also be required to develop and consult on a registration standard and any required guidelines. A proposal to introduce an endorsement may be initiated by government, consumers, professional organisations and/or the Board.

It is possible that a particular model of prescribing by pharmacists may develop without any further regulatory involvement from the Board. This may occur where local governance arrangements establish the supporting regulatory framework in a similar way to the administration of vaccines by pharmacists.

There are a range of roles and responsibilities for various stakeholders. State and territory drugs and poisons legislation provides the authorisation to prescribe scheduled medicines. An endorsement is an indication that a health practitioner is qualified to prescribe scheduled medicines as described in the endorsement, it does not authorise the practitioner to prescribe the scheduled medicines. Therefore, changes in legislation would most likely be required for any model/s of prescribing that the profession may pursue. The profession (including professional organisations) would need to engage with local state and territory health departments for any changes in legislation.

Education providers would have a key role in addressing any gaps in the competencies required to prepare students to the level of competence required to prescribe under a particular model. Ensuring that any potential model of pharmacist prescribing is appropriately renumerated would require engagement with local health departments if funding is to occur through the Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedules (MBS).

Consumer groups would also have a role in developing any potential model of pharmacist prescribing and would need to be engaged throughout the process to ensure that the needs of the public were met. Engagement with other health professionals would also need to occur in developing a prescribing model to ensure that systems are in place to support collaboration and clear communication between practitioners involved in the patient's care.

Endorsement for scheduled medicines

If the profession decides to pursue a model of pharmacist prescribing that would require an endorsement for scheduled medicines, the Australian Health Ministers' Advisory Council (AHMAC) guidance should be read to understand the information needed for the Board to recommend a proposal for endorsement to the Ministerial Council. AHPRA's *Guide for National Boards* outlines that the development of a proposal for endorsement for scheduled medicines involves a cycle of development, implementation, monitoring and evaluation. The key stages in the process (Figure 1) are:

- concept development
- National Board submission preparation
- ministerial approval process
- implementation, and
- monitoring.

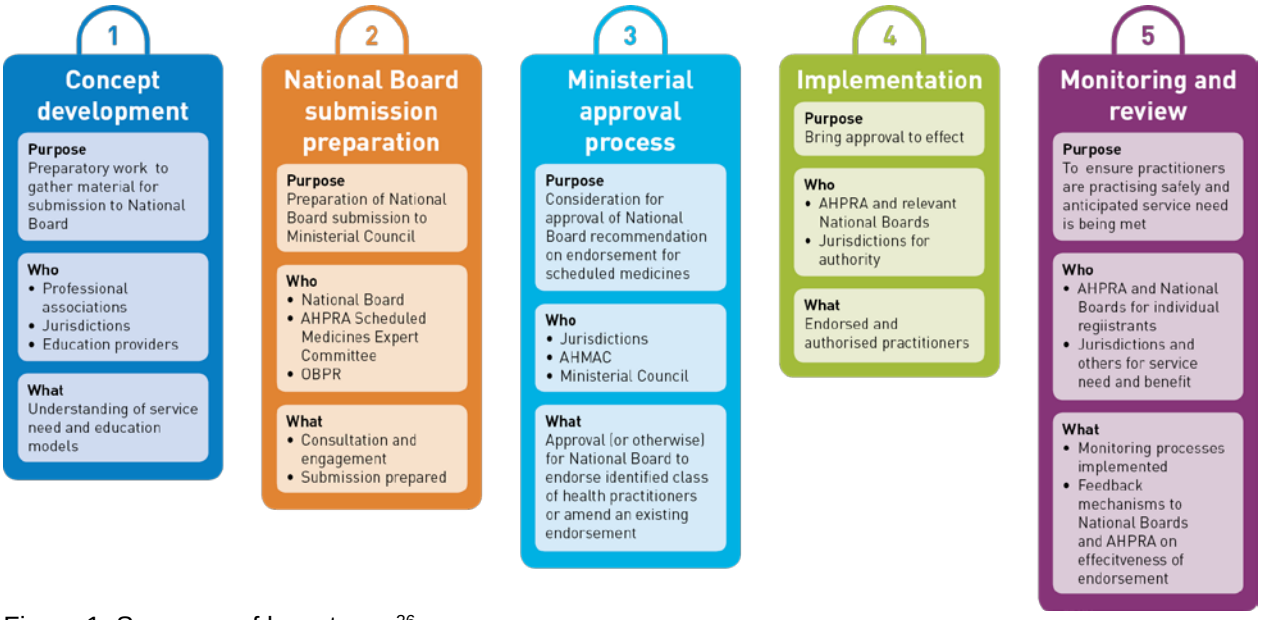

Figure 1: Summary of key stages[26]

The summary of key stages in Figure 1, clearly outlines the outcomes of each stage and the roles of stakeholders in doing the preparatory work to achieve those outcomes.

If an endorsement were sought and approved, the Board and AHPRA would take the necessary administrative actions to give effect to the Ministerial Council approval. These actions would include:

- approving new or amended program accreditation standards
- approving changes to qualifications required for endorsement
- establishing administrative arrangements, such as forms to receive and process applications for endorsement
- approving changes to guidelines or clinical protocols, and
- establishing mechanisms to evaluate the impact of the changed arrangements.

The Board and AHPRA do not have responsibility for:

- giving effect to the approved endorsement by conferring the necessary authorities under legislation
- developing heath system requirements such as clinical governance structures, and
- integrating endorsed pharmacists into health funding systems such as the Pharmaceutical Benefits Scheme (PBS) and Medicare Benefits Schedules (MBS)

Following Ministerial Council approval, each minister would endeavour to give effect to the Ministerial Council-approved endorsement and to confer the necessary authorities under state or territory laws. This may require changes to relevant legislation.

Next steps

After the feedback period has closed the Board will assess the feedback and publish a report. The report is expected to provide further helpful information about the concept development stage outlined in Figure 1. This may include recommendations about:

- any additional work required
- evidence to be gathered if sustainable prescribing models in the public interest are supported
- an indication of the roles of the profession and stakeholders in progressing next steps, and
- details about any proposed regulatory work that would need to be completed to support any proposals, including whether the Board would be required to progress any proposals to the Ministerial Council.

The Board will subsequently continue to engage with the profession, government and stakeholders about any pharmacist prescribing proposals to discuss pertinent issues that must be addressed to ensure that the public is protected.

Questions for feedback

Although most forum participants indicated that the profession should initially proceed with prescribing under a structured prescribing arrangement and/or prescribing under supervision, there is opportunity for you to give feedback on all three models of prescribing.

Your feedback on the following questions is sought. A separate Word document is provided for you to complete and submit by the closing date of Monday 15 April 2019.

Some of these questions request details of evidence to support your views or views of your organisation. This discussion paper and other reports about prescribing published by the Board reference published information and evidence about pharmacist prescribing locally and overseas. The Board is seeking further details about additional evidence (published or unpublished) that you may be aware of or believe should be considered. Evidence could include information about new initiatives in practice currently being developed or in progress; or relevant information about prescribing by other non-medical health professions that may provide further information or evidence to inform pharmacist prescribing. For example, evidence may include data demonstrating cost effective health outcomes or qualitative data demonstrating patient satisfaction with pharmacist prescribing.

		Prescribing under a structured prescribing arrangement	**Prescribing under supervision**	**Autonomous prescribing**
	PUBLIC NEED			
1.	How would these models of prescribing by pharmacists fulfil a public need?			
	EVIDENCE (published or unpublished)			
2.	What is the evidence that these models of prescribing by pharmacists would be a safe and effective way of improving access to medicines for the community?			
3.	What is the evidence that these models of prescribing by pharmacists support the *Quality Use of Medicines (QUM)*, i.e. judicious, safe, appropriate and efficacious use? (For example, by minimising overuse of medicines, reducing adverse events, improving health outcomes and/or other elements outlined in QUM)			
4.	Are there any gaps in the evidence for pharmacist prescribing under these models? If so, how could this evidence be obtained?			
	EDUCATION AND TRAINING			
5.	What education requirements (if any) would pharmacists with general registration need to complete to competently prescribe under each model? (i.e. postgraduate education)			
6.	Are current undergraduate program providers addressing the competencies to prescribe under each model? If not, what are the gaps and how can they be addressed?			

		Prescribing under a structured prescribing arrangement	Prescribing under supervision	Autonomous prescribing
7.	Before being authorised to prescribe under each model, would a pharmacist need to accumulate a minimum period of supervised practice under the supervision of an authorised prescriber (e.g. during the internship, before gaining general registration or after gaining general registration)?			
8.	Before prescribing under each model, would a pharmacist need to have achieved a minimum period of practice experience as a pharmacist with general registration? If so, for what period?			
9.	Would pharmacists prescribing under each model need to meet different annual CPD requirements to pharmacists who do not prescribe?			
	REGULATION			
10.	Would these models of prescribing by pharmacists require additional regulation by the Pharmacy Board or could it be adequately governed through relevant jurisdictional policy or legislation?			An endorsement for scheduled medicines in accordance with Section 94 of the National Law would be required for pharmacists to prescribe under this model.
11.	What are the risks associated with each model of pharmacist prescribing and how could they be managed?			
	OTHER			
12.	What factors would contribute to sustaining each model of pharmacist prescribing if introduced?			
13.	Do you have any additional comments about these models of prescribing by pharmacists?			

Appendix A

The tables below are adapted from the background paper for the Registered Nursing/Midwifery Prescribing Symposium[27] and are also found in the Prescribing Forum background paper.

State or territory	Prescribing	Limited prescribing	Possess medicines only	Possess and supply	Administer in accordance with protocol but not prescribe	Prescribe or supply	Relevant state or territory legislation
New South Wales	Medical practitioner Dentist Veterinary practitioner Nurse practitioner Midwife Optometrist Podiatrist	Pharmacist (prescribe Schedule 2 & 3)	Medical superintendent of hospital (possess medicines only unless is an authorised prescriber)	Dental therapist Oral health therapist Dental hygienist Ambulance officer Registered nurse involved in vaccination program			Poisons Act 1966 Poisons and Therapeutic Goods and Regulation 2008
Victoria	Medical practitioner Dentist practitioner Veterinary practitioner Nurse practitioner Authorised registered midwife Authorised: - optometrist - podiatrist			Registered nurse			The Drugs, Poisons and Controlled Substances Act 1981 The Drugs, Poisons and Controlled Substances Regulations 2006

State or territory	Prescribing	Limited prescribing	Possess medicines only	Possess and supply	Administer in accordance with protocol but not prescribe	Prescribe or supply	Relevant state or territory legislation
Queensland	Medical practitioner Nurse practitioner Endorsed midwife Surgical podiatrist	Pharmacist (prescribe Schedule 2 & 3)		Indigenous health worker Registered nurse Midwife Oral therapist		Physician assistant (under supervision of medical officer)	Health Act 1937 Health (Drug and Poisons Regulation 1996) Health (Drugs and Poisons Regulation 1996)
Western Australia	Medical practitioner Dentist Veterinary surgeon Nurse practitioner Endorsed: - midwife - optometrist - podiatrist	Pharmacist (prescribe Schedule 2 & 3)		Registered nurse			Medicines and Poisons Act 2014
South Australia	Medical practitioner Dentist Veterinary surgeon	Pharmacist (prescribe Schedule 2 & 3) Nurse practitioner (Schedule 2, 3, 4 or 8 within scope of practice approved by their Local Health Network)			Registered nurse Registered midwife		Controlled Substances (Poisons) Regulations 2011

State or territory	Prescribing	Limited prescribing	Possess medicines only	Possess and supply	Administer in accordance with protocol but not prescribe	Prescribe or supply	Relevant state or territory legislation
Tasmania	Medical practitioner Dentist Veterinary surgeon Nurse practitioner Endorsed midwife	Pharmacist		Registered nurse Midwife			Poisons Act 1971 consolidated 2015 Tasmanian poisons regulations 2008
Australian Capital Territory	Medical practitioner Intern medical practitioner Dentist Veterinary surgeon Nurse practitioner Endorsed midwife	Pharmacist		Health practitioners employed at institutions Nurse Midwife Trainee dentists (under supervision of dentist) Dental hygienist Dental therapist Oral health therapist Optometrist Podiatrist			Medicines, Poisons and Therapeutic Goods Act 2008 Medicines, Poisons and Therapeutic Goods Regulation 2008 Drugs of Dependence Act 1989 Drugs of Dependence Regulation 2009

State or territory	Prescribing	Limited prescribing	Possess medicines only	Possess and supply	Administer in accordance with protocol but not prescribe	Prescribe or supply	Relevant state or territory legislation
Northern Territory	Medical practitioner Dentist Veterinarian Nurse practitioner Endorsed midwife Optometrist Podiatrist Podiatric surgeon	Pharmacist (prescribe Schedule 2 & 3)		Aboriginal and Torres Strait Islander health practitioner Approved ambulance officers Dental therapists Dental hygienists Oral health therapists Nurse and midwife			Medicines, Poisons and Therapeutic Goods Act Medicines, Poisons and Therapeutic Goods Regulation

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