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Tēnā koe

Amendments to the schedule of the Medicines (Designated Pharmacist Prescribers) Regulations 2013 and Schedule 1B of the Misuse of Drugs Regulations 1977

Thank you for giving The Royal New Zealand College of General Practitioners the opportunity to comment on the Amendments to the schedule of the Medicines (Designated Pharmacist Prescribers) Regulations 2013 and Schedule 1B of the Misuse of Drugs Regulations 1977.

The Royal New Zealand College of General Practitioners is the largest medical college in New Zealand. Our membership of 5,500 general practitioners comprises almost 40 percent of New Zealand's specialist medical workforce. Our kaupapa is to set and maintain education and quality standards for general practice, and to support our members to provide competent and equitable patient care.

SUBMISSION

Authorised and Designated prescribers

We note that pharmacist prescribers are classified as designated prescribers, a subclass of authorised prescribers. As designated prescribers they prescribe from a list of medications. Dietician prescribers and Registered Nurse prescribers are also designated prescribers and have separate lists.

Members of the following professions are classified as authorised prescribers and may prescribe without the limitation of such a list:

- Medical practitioners
- Dentists
- Midwives
- Optometrists
- Nurse practitioners

Designated Pharmacist prescribers

We note that Pharmacist Prescribers comprise a small but increasing proportion of all pharmacists. Of the 3,906 pharmacists practising in New Zealand in 2020, 34 were registered in the pharmacist prescriber scope of practice, an increase from 15 in 2016.[1] Pharmacist prescribers have undertaken a four-year pharmacy undergraduate degree followed by three years of post-graduate training and a further intern year.

[1] https://pharmacycouncil.org.nz/wp-content/uploads/2021/03/Workforce-Demographic-Report-2020.pdf accessed 5/8/21

Pharmacist prescribers prescribe within collaborative and multidisciplinary health team settings including general practice, and only prescribe medicines within their specific area of practice. They do not prescribe in community pharmacies. One of the Pharmacy Council requirements for entry into the Pharmacist Prescriber scope of practice is the submission of a practice plan which is endorsed by the clinical lead of their collaborative healthcare team.[2] In general practice settings we would expect this to be the general practitioner.

Although the designated pharmacist prescriber is not the primary diagnostician in the collaborative healthcare team, they must be able to carry out clinical assessments and monitoring that are relevant to the medicines and conditions for which they prescribe.

The schedule for pharmacist prescribers

The current schedule which has been in effect since the Medicines (Designated Pharmacist Prescribers) Regulations passed into legislation in June 2013 lists 1,517 prescription medicines. The schedule requires updates to include changes in prescription medicines since 2013.

We note the Pharmacy Council has recommended 198 prescription medicines should be added to the schedule of the Medicines (Designated Pharmacist Prescribers) Regulations 2013. In addition, they have recommended that three controlled drugs should be added to schedule 1B of the Misuse of Drugs Regulations 1977 which specifies controlled drugs that may be prescribed by designated pharmacist prescribers.

The consultation document states that the Pharmacy Council made their recommendations after working with pharmacist prescribers and the Ministry of Health. The document does not give any information on the basis on which these medications have been selected and we consider this level of transparency is important to the level of support for the recommendation.

Prescribing is one therapeutic option

The College considers that while medication plays a significant role in healthcare it is not the only treatment modality that should be considered and may not be the most appropriate option for many patients. For some conditions, for example depression and anxiety, medication is a more accessible option than other therapies that might otherwise be employed.

Prescribing carries risk to the patient from the adverse effects of medication. Prescribing is only indicated when the likely benefits outweigh the potential harm. The College supports the Choosing Wisely approach which seeks to reduce harm from unnecessary and low-value tests and treatment. [3]

Collaborative teamwork

The College considers that the requirement for pharmacist prescribers to work in multidisciplinary teams, and the extensive training and experience of pharmacist prescribers are key to the safety and value of pharmacist prescribing.

The collaborative element of the role is more important than the content of the list of medications that can be prescribed by pharmacist prescribers.

The current system of gazetting a list of medications, to ensure there are no barriers to prescribing by pharmacist prescribers if working in a situation where it is appropriate to prescribe, is inefficient and cumbersome. It has been seven years since the last update and the Pharmacy Council has attempted to

[2] https://consult.health.govt.nz/pharmacy/proposed-amendments-to-the-specified-rx-med-list/ accessed 12/8/21

[3] https://choosingwisely.org.nz/resources/ accessed 12/8/21

anticipate which medications may be approved for use in New Zealand in coming years and has included them in the list in anticipation of their approval. It is however possible that other unanticipated medications will be approved, and pharmacist prescribing of these medications will have to wait until the next update. These medications will not be able to be prescribed prior to Medsafe approval.

Many of the medications on the list are poorly aligned with the roles that pharmacist prescribers fulfil. The intent was to ensure that pharmacist prescribers have access to all medications however we understand that inclusion on the list does not imply that these medications will be prescribed by pharmacist prescribers.

Controlled drug prescribing is a good example of the need for collaborative teamwork to ensure that drug seekers do not receive additional prescriptions from multiple prescribers. In these cases, we consider it is imperative that prescribers liaise directly with the patient's supervising clinician. In the community the patient's supervising clinician is likely to be a general practitioner.

CONCLUSION

The College is supportive of pharmacist prescribing as it currently occurs in New Zealand. Safeguards exist to address the potential risks of non-medical prescribing, and ensure collaboration with a responsible diagnostician, and in the community setting this would usually be a general practitioner.

The College considers that the existence of a list of medications makes minimal contribution to patient safety, and the lack of an efficient process to ensure that new medications are promptly added to the list creates barriers to the benefits of pharmacist prescribers.

Please don't hesitate to contact the College at policy@rnzcgp.org.nz if you have any questions, or require additional information.

Nāku noa, nā

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