New Zealand Nurses Organisation Submission

to the

Health Select Committee

on the

Medicines Amendment Bill

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ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa represents our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Medicines Amendment Bill (the Bill) and progressing urgently needed changes to the Act to remove the barriers preventing timely, cost effective, and safe access to medicines which enhance the health of New Zealanders.

2. NZNO has consulted its staff and members in the preparation of this submission in particular members of our specialist Colleges and Sections; te Runanga o Aotearoa; regional councils and NZNO Board members; and professional nursing, legal, policy, and research advisers.

3. We have also consulted extensively with other nursing organisations and leadership groups including the College of Nurses Aotearoa (NZ) Inc.; the New Zealand Council of Deans; Nursing Educators in the Tertiary Sector; the District Health Board Lead Directors of Nursing; Te Ao Māramatanga: New Zealand College of Mental Health Nurses; Family Planning New Zealand (FPNZ); the Nurse Practitioners Advisory Committee (NPAC); the Royal New Zealand Plunket Society; and the Nursing Council of New Zealand (NCNZ).

4. In general, NZNO believes the Bill achieves its aim of modernising medicines legislation and **supports:**

    - the amended definitions of medicine, medical device and therapeutic purpose;
    - moving nurse practitioners into the authorised prescriber class;
    - expanding regulatory powers to provide for new standards and innovative practice, including electronic prescribing; and
    - the technical and consequential amendments, for which we have additional recommendations.

5. However, the Bill is less successful in satisfactorily aligning the prescribing framework with the Health Practitioners Competence Assurance Act 2003 (HPCAA), which provides for the regulation of health practitioners, including their competencies and scopes of practice.

6. In common with the above nursing groups, NZNO:

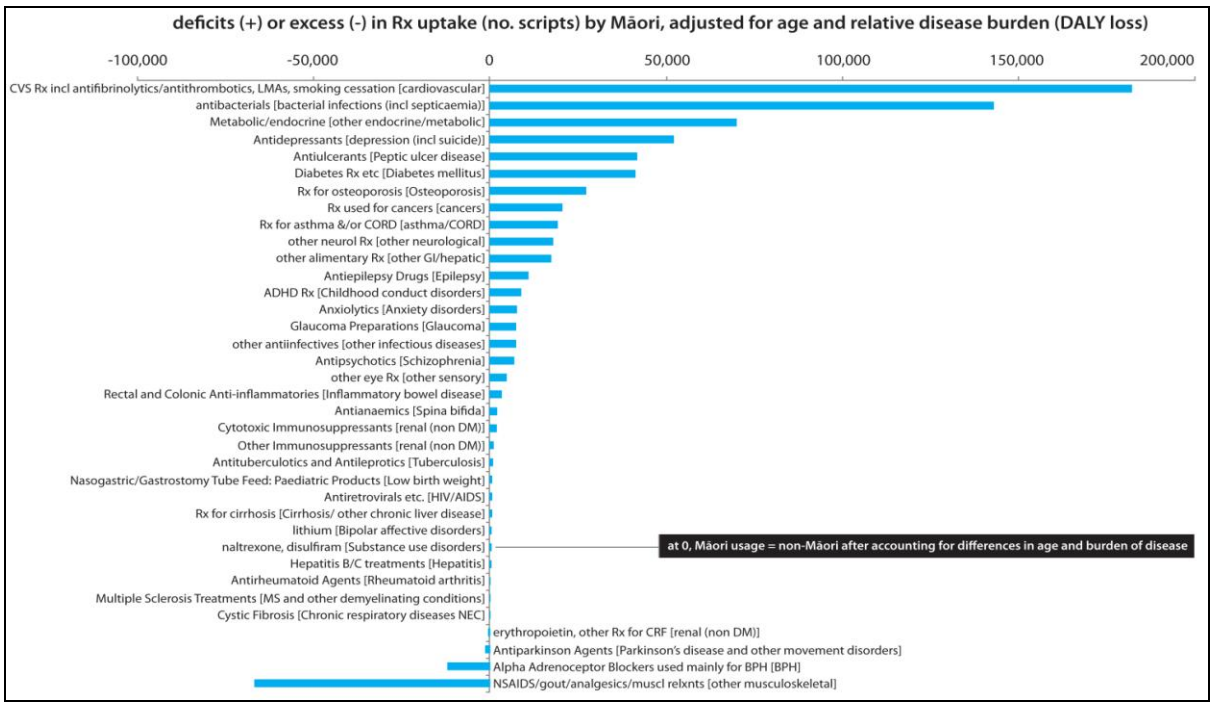
    - **supports** the authorised and designated categories of prescriber;
    - **does not support** the additional categories of delegated or temporary prescriber; and
    - **recommends** that the regulating bodies i.e. the appropriate Responsible Authorities (RA) under the HPCAA, be responsible for

determining the requirements for designated prescribing within a defined area of practice.

7. NZNO would like to make an oral submission to the Committee.

DISCUSSION

8. How important is this legislation? Few New Zealanders would deny the potential of medicines to improve health, yet many are not aware of critical influence that the prescribing regime has on determining who gets which medicines.



9. This histogram compiled by Marama Parore PHARMAC Manager "Access and Optimal Use; Maori Health" showing the comparative access Māori have to funded medicines, graphically illustrates a fundamental cause of health disparities. The central line indicates equity; the coloured bars indicate the degree of inequity. It is abundantly clear that Māori are not getting the medicines that prevent Aotearoa's most common preventable/manageable diseases – cardiovascular disease, infections, diabetes, asthma.

10. This legislation has the potential to make a difference in reducing the significant sociological and financial costs of health disparities, because it will determine the prescribing regime governing access to medicines. NZNO invites the Committee to keep in mind the hundreds of thousands of New Zealanders whose lives could be significantly improved and extended if they had access to appropriate medicines.

11. Historically, nursing as a discipline has had a close association with the administration of medicines and the assessment of the client in relation to them. Today, this association has expanded to include important and complex aspects regarding knowledge of medicines and appropriate dosage, their administration and control, side effects, suitability for the client, compliance, and nurses' ethical and professional responsibilities. The laws regarding the regulation of medicines, their storage, administration, and documentation are also a part of the awareness within which nurses practice (NZNO, 2012 Guidelines for nurses on the administration of medicines).

12. The priorities for medicines legislation must be to protect the public from risk and to ensure New Zealanders have safe, timely access to the medicines they need. Current legislation has proved a barrier to the latter. The regulated health workforce has expanded and changed in response to advances in medicines, new models of care, and changing health needs, yet access to prescription medicines remain inappropriately limited, to the detriment of New Zealanders' health.

13. Nurses - in particular Nurse Practitioners who have a minimum of eight years training, post-graduate education and clinical experience, and other advanced practise nurses - are consistently frustrated by their inability to practise to the full extent of their scope because they cannot access appropriate medicines for clients in a timely and efficient manner. Time and resources are wasted on duplicative and circuitous processes, which compromise, rather than improve, health care. Additional appointments with doctors to sign off on

routine repeat scripts, for example, are a common deterrent for the most impoverished and isolated New Zealanders for whom the potential to benefit from medicines for chronic diseases like diabetes and asthma is significant.

14. Nurses are educated to refer appropriately; expert nurses, working in collaboration with medical practitioners, can safely prescribe within the defined area of their expertise, as has been evidenced by decades of practice in many other countries. Aotearoa has not seen the health benefits from significant extra resourcing of primary health care partly because it has failed to implement its own health policies in progressing nurse prescribing.

15. New and expanded scopes of practice that build on clinical experience, expertise and continuing education, and multidisciplinary collaboration and teamwork should enable freer access to prescription medicines across the regulated health workforce, without compromising safety.

16. Medicines legislation must be consistent with the HPCAA, which provides for the regulation of health practitioners, their fitness to practise, competencies and scopes of practice, including prescribing and other protocols around medicines. This is a safe regulatory framework that facilitates the development and utilisation of a flexible, integrated health workforce, and considerably reduces the need for complexity around the prescribing continuum.

17. Accordingly, NZNO recommends that *no addition* to the current prescribing categories of authorised and designated prescriber be made because it is unnecessary; NZNO does not support any dependent prescriber category, since that would be inconsistent with the HPCAA.

18. Regulated practitioners work within wider interdisciplinary teams, although they practise in their own right and are responsible and held accountable for their own practice. An authorised prescriber cannot and should not be responsible for a dependent prescriber; nor should the authority to determine

who may prescribe rest with another practitioner, as this falls within the domain of the relevant Responsible Authority.

Section 2(1) Interpretation of "authorised prescriber"

19. NZNO warmly supports the reclassification of NPs as authorised prescribers.

20. Paragraph (c) *a practitioner* indicates *a medical practitioner* and *a dentist* according to the Act. Practitioner is generally used as a generic term to describe all practitioners, and is not necessarily confined to health. We recommend amending to specify the discipline as is consistent with the other paragraphs.

21. We recommend deleting paragraph "*(e) a designated prescriber"* from the definition of authorised prescriber, as it is confusing when other parts of the Bill refer to both "authorised prescriber" and "authorised prescribers who are not designated prescribers".

22. Omitting designated prescriber from the definition of authorised prescriber would clarify that they are separate prescribing categories, and would have the added advantage of allowing the term “authorised prescriber” to be used consistently instead of having to substitute "a practitioner, registered midwife, nurse practitioner or midwife".

23. NZNO also suggests that consideration could be given to allowing for the inclusion, subject to RA/ministerial approval, of other regulated health practitioners as “authorised prescribers”. The serious consequences of NPs misplacement in the designated prescriber category, and the lengthy period taken to (partially) address them, testifies to risks of specifying scopes of practice that may in time become legislative ‘strait jackets’; having the ability to add to the authorised prescriber class may provide a more flexible and enabling framework for the future.

Section 2(1) Interpretation of "designated prescriber"

24. The **designated prescriber** category is an important mechanism for allowing suitably qualified and experienced health practitioners, such as registered nurses (RNs), to prescribe medicines.

25. NZNO strongly supports the designated prescriber category and the opportunity it gives to develop and utilise clinical expertise and skills across the workforce and ensure 'Better, sooner, more convenient health care'.

26. To date, however, only the 11 diabetes nurse specialists enlisted by Health Workforce New Zealand for the pilot Diabetes Nurse Prescribing Programme have utilised the designated prescriber category.

27. Such a narrowly focused and limited rate of uptake is entirely insufficient to effect the changes needed to improve health outcomes through better access to taxpayer-funded prescription medicines. There is also a risk of having to replicate the same cumbersome process for every area of health where advanced practice nurses, such as clinical nurse specialists (CNS) (and those from other disciplines) could make a significant difference - for instance, with respiratory disease, palliative care, gerontology, emergency care.

28. It is essential that the legislative framework for medicines is enabling, and supports safe, flexible processes for prescribing being made by the RA, which is the appropriate body to set the requirements for prescribing within a defined area of practice.

29. NZNO recommends an additional paragraph to the definition of designated prescriber to avoid problems with access to classes of drugs due to exclusions of restricted or pharmacy only medicines. "A **designated prescriber** means a person who -

> *belongs to a class of registered health professionals authorised by regulations to prescribe medicines listed in the Medicines Schedules of the Medicines Regulations 1984."*

Section 2(1) Interpretation of "delegated prescriber" and new sections 47A and B Delegated prescribing rights

30. NZNO **does not support** the proposed new category of **delegated prescriber**, for which no evidence or policy has been advanced.

31. Though the Deputy Director-General of Health, David Wood, suggested in the Regulatory Impact Statement on the Medicines Amendment Bill (September 20th, 2011) that "The proposal for delegated prescribing was publicly consulted on in 2007" and that "There was strong support for the general proposal", this is not NZNO's recollection. Discussion on alternative prescribing at that time centred on collaborative prescribing and there was insufficient surety and detail about what that meant and how it would be implemented to reach any consensus, cross-disciplinary or otherwise.

32. We are not aware of any opportunities for discussion since, so it is difficult to see on what basis the claim for general support rests. Appropriate consultation and policy analysis has not occurred, the limited role of the Responsible Authority does not assure public safety and NZNO believes there are significant difficulties in implementing such a category.

33. There is a high degree of uncertainty and confusion about how the delegated prescriber category is intended to work in practice.

34. The nursing profession, which comprises half the health workforce and covers all health settings, believes that the delegated prescriber category is not required, and that the authorised and designated categories are sufficient to enable safe access to prescription medicines and meet future health need.

35. The rationale for its inclusion in the prescribing continuum is still not clear.

36. It is also contrary to the HPCAA since it is proposed that delegated prescribing rights to a class of registered health professionals be approved in part by "an authorised prescriber". Under the Act, it is not authorised

prescribers who determine the scopes of practice - within which the prescribing tool fits - but RAs.

37. If, as has been suggested, delegated prescribing is intended as an "extension of Standing Orders" approved in the same way through the issuing of an order, the implication is that the delegated prescriber would not be given a prescriber's number or have it recorded on the practising certificate. That gives rise to a number of questions to which the answers are unclear.

38. The risk is that the delegated prescriber category will require investment in resources for education, training, monitoring etc, that would be more appropriately focused on developing the processes needed to facilitate designated prescribing. For instance, the cost of education is a major barrier preventing RNs and service providers for whom it would be useful, from seeking designated prescriber authority.

New section 47C Temporary prescribing rights

39. This is another new category for which no evidence or rationale has been offered and which has not been canvassed within the sector. For this reason NZNO finds it difficult to support.

40. Accordingly, NZNO does not support ministerial powers to grant temporary prescribing rights to a class of registered health professionals for up to two years (one year with a one year right of renewal).

41. As with the delegated prescriber category, the temporary prescriber would add yet another layer of complexity to the somewhat crowded continuum of medicines regulation this Bill proposes, which would include from standing orders, various clinical groups of delegated prescribers, designated prescribers, temporary prescribers and authorised prescribers, all requiring regulation, auditing, education and training.

42. Such complexity is potentially confusing, unsafe, expensive and unnecessary.

Section 105 (1) (qa) Regulations

43. “description of medicines” has been omitted from this section and needs to be reinstated as some classes of medicines contain prescription and restricted and pharmacy-only medicines. As designated prescribers can only prescribe prescription medicines the classes are not able to be used as too many exclusions would be required.

Consequential Amendments

44. An amendment to the **Misuse of Drugs Regulations** to include NPs as prescribers of controlled drugs is required to ensure they do not continue to be able to prescribe drugs for three days only.

45. There also needs to be a consequential amendment to the **Standing Order Regulations 2011** to include NPs as issuers of standing orders.

CONCLUSION

46. In conclusion, NZNO **supports** the Bill and recommends that you:

- **note** our warm approval for moving NPs into the authorised prescriber category;
- **delete** the additional categories of delegated or temporary prescriber;
- **agree that** the regulating bodies i.e. the appropriate Responsible Authorities (RA) under the HPCAA, be responsible for determining the requirements for designated prescribing within a defined area of practice;
- **add** "belongs to a class of registered health professionals authorised by regulations to prescribe medicines listed in the Medicines Schedules of the Medicines Regulations 1984." to the definition of designated prescriber, **section 2(1)**;

- **add** *"or descriptions of medicines"* to **section 105(1)(qa)** after *"specified class of prescription medicines"*; and
- **amend** the Misuse of Drugs Regulations and Standing Order Regulations 2011 as indicated to enable NP authorised prescribing.

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