More prescribing the better the health outcomes – where’s the evidence?
Kate Baddock

"Top of scope" is a phrase that seems to roll off the tongue of people in high places, not always with any evidence to back up the proposition of just what this means.

As the various medically allied professions all vie for prescribing rights, one would be forgiven for thinking top of scope means being able to prescribe. But is that justified? And is there any international evidence to suggest that is where all these professions should be heading?

A related but clearer phrase is "scope of practice". This defines what can and cannot be done by an individual in a given profession. Now, it is reasonable to look at extending scopes of practice, but does this mean reaching for the prescribing pen?

Is this the solution to a problem not actually identified?

Stewart, in his research into nursing autonomy had this to say: "Nurses in critical care and outpatient clinics were more likely to describe expanding or extending their practice beyond usual nursing procedures and responsibilities. Examples included protocols for titrating medications based on their assessments, and specialised clinical competencies related to new technologies and procedures."

Australia has been looking at extended roles for pharmacists. No one would argue with a pivotal comment on that work, made by Bessel and colleagues in a 2005 report on developing pharmacy practice models: "It is vital that we utilise the capacity of the pharmacy workforce to improve medication management and health outcomes."

Working within the multidisciplinary primary care team, with pharmacists using their expertise to help ensure the patient gets the right medication in the right way to improve health, is an excellent way forward, especially when funding streams are aligned to support this kind of working together.

Let us be clear, if there are more prescribers in the marketplace, more prescriptions will be written. What of the pharmaceutical budget then? It is more of a skill and a matter of judgement to know when you should not prescribe when able to, than to prescribe because you have just been given the power to do so.

To come back to the nagging question, just what is the problem that will allegedly be solved by having more people prescribe? More people seen? Greater access to prescription writers? Will it mean better health outcomes? If we apply the principle of workforce redesign, then what about principle 11, which states that all reform is based on an assessment of the best available evidence and /or practice.

In Australia, extended scopes of practice of both pharmacists and nurses in primary care settings have recently been studied, with many of the interventions reviewed involving the use of disease management or health promotion guidelines. The comment was made that, while there were improvements in the process of care and patient level outcomes, task substitution did not result in reduced use of health services.

Various non-medical groups can already prescribe medicines in New Zealand. In recent months, further allied health professions and community nurses have sought to have independent prescribing rights extended to them under the guise of working at the "top of scope".
What is true is that efficiencies come when everyone is working to the top of their licence.

My final quote is from Richard Murray, president of the Australian College of Rural and Remote Medicine. He writes: “Access to effective, affordable care on the basis of need will be assured by generalist-led health care, empowered patients, judicious use of consultants, a focus on populations as well as individuals and clever use of technology including tele-health.”

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