



# ADOPTING AND IMPLEMENTING PRESCRIPTION RIGHTS FOR NURSES IN INDIA

POLICY BRIEF

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## Introduction

- This policy brief outlines policy options, policy recommendations and implementation suggestions for adopting and implementing nurse prescription in India.
- Such an initiative is also an opportunity to strengthen the health workforce response in providing primary health care in pandemic situations such as COVID-19 and during other epidemics.
- A global systematic review of literature related to nursing prescription and legal analysis to generate evidence, guidance and policy options for adopting and implementing nurse prescription in India.
- The structure of this brief is as follows: it describes the rationale for nurse prescriptions and moves on to presenting policy options on specific dimensions such as a model of prescription, legal changes and model of education/training. A list of policy recommendations is presented that emerges from the examination of the policy options.<sup>i</sup>
- This brief also presents implementation considerations to be kept in mind (related to methods for simplifying and standardizing prescription, education/ training and stakeholder consultation) followed by specific implementation suggestions.

## Rationale for nurse prescriptions

- In India, on average, one government doctor serves more than 11 000 people, and ten times more than the WHO mandated doctor: population ratio of 1:1000.<sup>ii</sup> Nurses can play a larger role in improving population health ameliorating HRH shortages if they are empowered to prescribe. Nurse prescription, in some form or the other, has been adopted in a large number of countries. Shortage of doctors, the urgent need to achieve universal health coverage and making more efficient use of the time and skills of different kinds of health professionals were reasons to introduce nurse prescriptions in different countries.



Fig. 1. Countries that have adopted various forms of nurse prescription<sup>iii</sup>

- A systematic review shows there is no major difference between nurses and physicians concerning clinical outcomes, perceived quality of care and patient satisfaction.<sup>iv</sup>
- A Cochrane review of 46 studies compared prescribing by doctors with prescribing by other healthcare professionals. Most of these studies were of chronic disease management in primary care settings. 44 of these studies were randomized controlled trials. Prescribers were nurses in 26 of these studies. The review found that patient outcomes after nurse or pharmacist prescribing were similar to those for medical prescribing. Patient adherence to medication, patient satisfaction and health-related quality of life were also comparable between nurse and pharmacist prescribers and doctor prescribers.<sup>v</sup>
- Nurse practitioners (Nps), trained in treatment and diagnosis are at the frontline in dealing with the Covid-19 crisis in the USA and their already expansive scope of practice is being further expanded in many US states.<sup>vi</sup>
- Though India is facing HRH shortages, it has not yet legally empowered nurses to prescribe. Recently, however, the passage of the National Medical Commission Act, 2019 has empowered the cadre of Mid-Level Health Workers (MLHWs) known as Community Health Providers (CHPs) to prescribe independently in primary healthcare set-ups and are under supervision in secondary healthcare centres. Nurses need to be empowered to prescribe independently both in primary and secondary healthcare, especially because of major health challenges such as the Covid-19 pandemic.
- Additionally, empowering nurses with advanced qualifications such as a Masters' Degree to prescribe independently within their area of competence would pave the way for the Nurse Practitioner Model, which is prevalent in countries such as the USA, Australia and New Zealand that are at the forefront of nursing reforms. It would lead to the better utilization of their skills, and clinical experience as well as competence.
- The adoption of nurse prescription and educational models tailored to train nurses for a prescription role is expected to lead to the following benefits:
  - ▶ Increased access and speed of patients in receiving medicines
  - ▶ High level of patient satisfaction<sup>vii</sup>
  - ▶ Regulation of prescription hitherto being done informally, especially where doctors are absent or tied up
  - ▶ Result in efficient use of nurse's experience and free up doctors' time to attend to complex cases
  - ▶ Result in better trained Bachelor of Science (BSc) nurses for taking up the Community Health Officer (CHO) positions at Health and Wellness Centres set up under Ayushman Bharat
  - ▶ Provide a strong impetus for improving nurse education in India

## Policy options

### Model of prescription

- Nurses may possess powers of independent or supplementary prescription. Under independent prescribing, it is the prescriber (nurse) who is responsible for the assessment of patient and prescription decisions. Under supplementary prescribing,

the doctor is responsible for the diagnosis. The supplementary prescriber (nurse) is responsible for managing and prescribing for conditions and medications listed in an agreed clinical management plan and cannot prescribe any other medication.<sup>viii</sup>

- Countries may opt for an independent or supplementary model of prescription or a blend of the two.

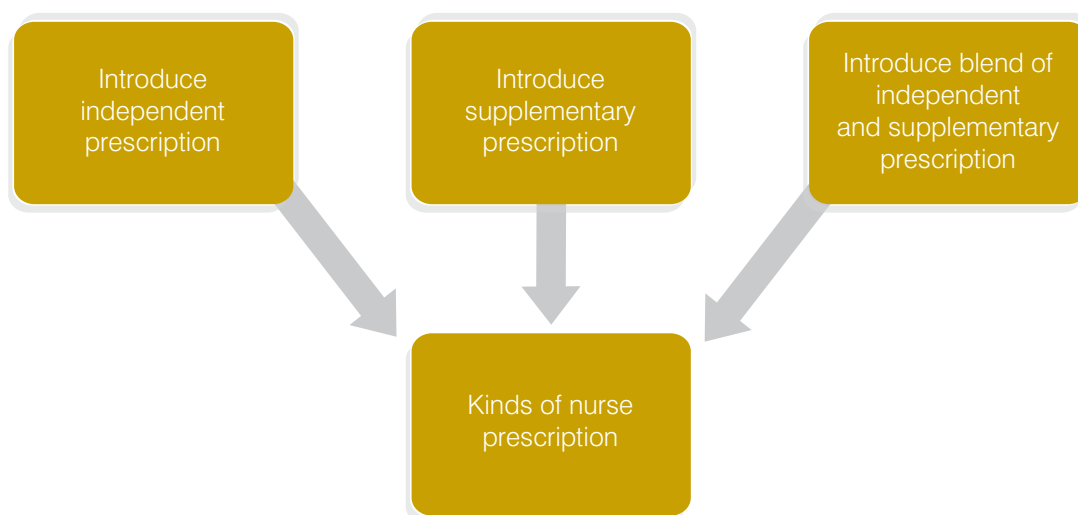


Fig. 2. Models of prescription for nurse prescription

### Policy option 1

**Countries can opt for independent nurse prescription rights for nurses:** In the UK, independent nurse prescribers have co-equal powers of prescription with doctors within their level of experience and competence.<sup>ix</sup> NPs in Australia, New Zealand and the USA can prescribe independently. In Poland, nurses with a Master's Degree or holding the title of a specialist may prescribe independently.<sup>x</sup>

### Policy option 2

**Countries can opt for supplementary nurse prescription rights for nurses:** Bachelor nurses in Poland and Denmark and family nurses in Estonia are authorized to perform continued prescribing.<sup>xi</sup>

### Policy option 3

**Countries can opt for a blend of independent and supplementary prescription rights for nurses:** In the UK, the Nurse and Midwifery Council approved prescriber training course equips nurses for Independent and Supplementary Prescribing (providing that they also complete the supplementary prescribing part of the course) so that nurses may prescribe both independently or as part of a clinical management plan agreed with doctors.

- Nurse prescription should be expanded in phases, and independent nurse prescribing should be initially introduced only for a limited range of drugs and conditions. The United Kingdom is a good reference point for the phased expansion of nurse prescribing.<sup>xiii,xiv</sup>

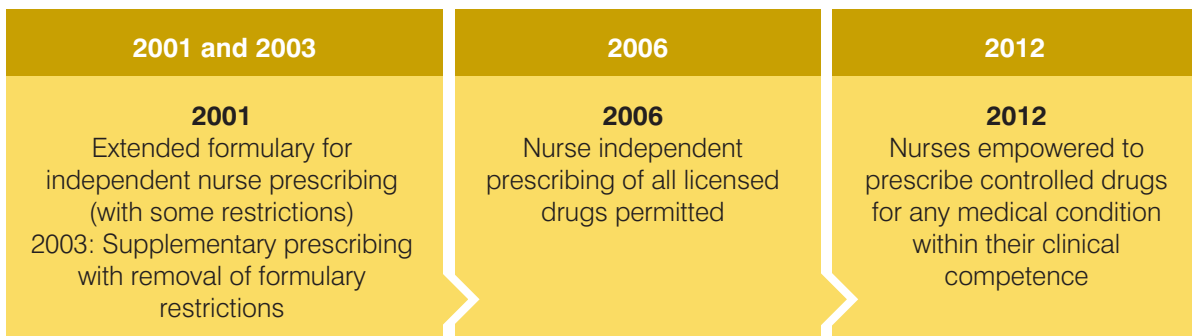


Fig. 3. Phase wise expansion of nurse prescription in UK

## Legal changes

- This section explores the policy options for legal changes required to implement nurse prescription in India.
- At present, only medical practitioners can prescribe medicines in India. The sale of medicines based on a 'valid prescription issued by a medical practitioner' is governed under the Drugs and Cosmetics Act, 1940 and the corresponding rules (there is however no definition of "Prescription" in the Drugs and Cosmetics Act).

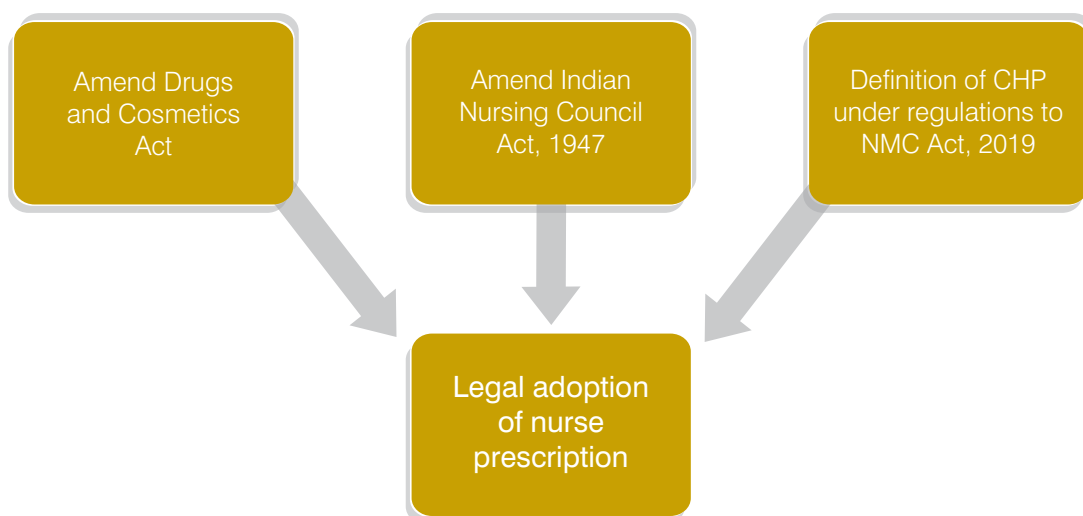


Fig. 4. Legal options for enabling nurse prescription

- **Policy option 1:** Introduce a definition for prescription in the Drugs and Cosmetics Act, which would legally enable prescription not only by registered medical practitioners but also by nurses. Medicines/drug laws are the most common framework for giving prescription rights to nurse prescribers. Countries such as the UK have used the route of amending the medicines law for authorizing nurses<sup>xv</sup> to prescribe.



- **Policy option 2:** Empower nurses to prescribe through the regulations to the National Medical Commission Act, 2019 (that would bring nurses under the ambit of CHPs). The National Medical Commission Act, 2019 in India already permits for supervised prescribing by Community Health Providers (CHPs) in secondary care and independent prescribing by CHPs in primary healthcare.
- The category of ‘CHPs’ mentioned in the National Medical Commission Act, 2019 may be defined (in the rules to the act) to include nurses with at least a Bachelor’s Degree so that nurses can independently prescribe in primary and preventive healthcare.
- **Policy option 3:** Empower nurses to prescribe by amending the nursing act.
- Countries such as South Africa<sup>xvi</sup> and the province of British Columbia in Canada have used the route of the Nursing Act to empower nurses to prescribe.
- Amending the Indian Nursing Council Act, 1947 would enable nurses with Masters’ Degree qualifications to prescribe independently in secondary care. It would thus enable the advent of the nurse practitioner system in India.
- The Supreme Court of India has specified that the “right to practise” a system of medicine is the right from which the “right to prescribe” certain medicines emanates (Mukhtiar Chand v. Union of India AIR1999SC468). Therefore the right to practise should not emanate from the Drugs and Cosmetics Act, 1940 which regulates the sale of drugs.
- Nurses can be empowered to prescribe independently in primary and preventive care by bringing them under the definition of CHPs under the National Medical Commission Act, 2019.
- The National Medical Commission Act already allows supervised prescribing by CHPs in secondary care. However, such supervised prescribing may be difficult to implement in a context where doctors are absent. There is therefore a need to empower suitably qualified nurses to prescribe independently in secondary care as well.
- Given the limitations of enabling independent nurse prescription in secondary healthcare under the National Medical Commission Act, the Indian Nursing Council Act, 1947 should be amended to enable the advent of prescribing nurse practitioners in India. This would enable nurses with a Master’s Degree qualification to prescribe independently in secondary care.
- Accordingly, Clause (2), with the following proposed wording, may be inserted in Section 11 of the Indian Nursing Council Act (INC), 1947.

**Proposed clause (2) in Section 11 of the INC Act 1947**

“No person, except those registered in the State Registers as provided under Section 11(1), shall:

- a. Be appointed as a nurse in any Clinical Establishment as defined under the Clinical Establishment Act and Rules, 2012.
- b. Assist a medical practitioner in conducting any medical procedure or treatment of any medical condition or administering any drugs.
- c. **Extend health services including** :<sup>xvii</sup>
  - (a) healthcare for the promotion, maintenance and restoration of health.
  - (b) prevention, treatment and palliation of illness and injury, primarily by:
    - (i) assessing health status
    - (ii) planning, implementing and evaluating interventions, and
    - (iii) coordinating health services

Provided that a person recognized as a nurse practitioner is permitted to practice medicine independently to the extent permitted under appropriate regulation.

A suggested definition of nurse practitioners: All persons who have received a nurse practitioner qualification recognized by the Indian Nursing Council and are registered with the Indian Nursing Council under Section 11 of this Act.

## Education and training for nurse prescribers

- As part of the introduction of nurse prescribing, it will be necessary to establish a training regime that provides nurses with necessary skills and competencies to prescribe safely and effectively. Alternative educational and training options for preparing nurses to prescribe are detailed below. These are based on four models of nurse prescription education prevalent in different countries:

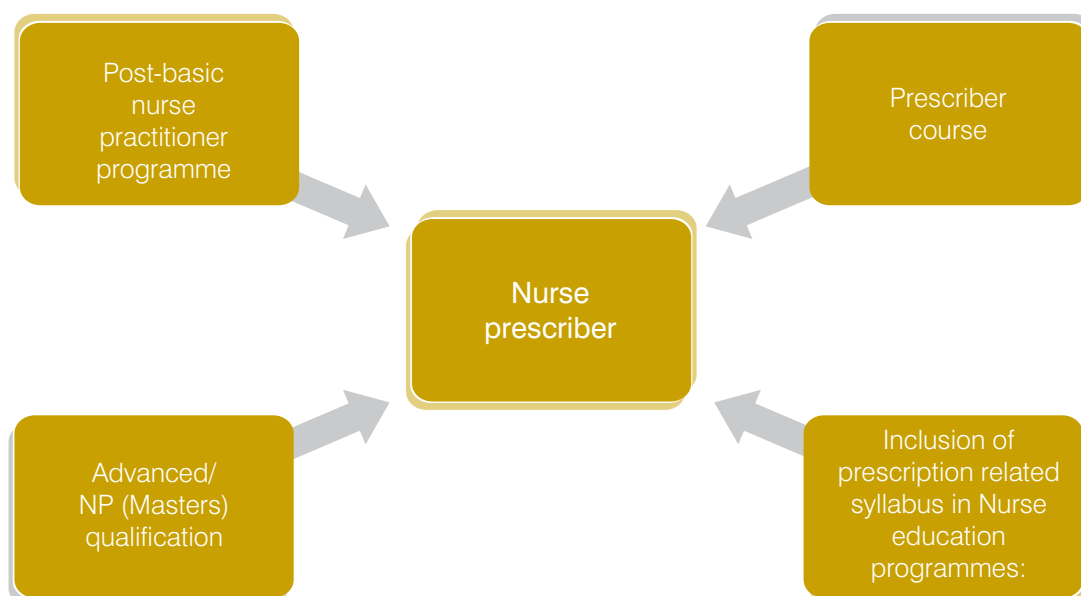


Fig. 5. Educational and training models for nurse prescription

### **Policy option 1: Advanced/NP (Masters) qualification**

- NP (Masters) qualification is required to be able to prescribe (e.g. Australia, USA).
- To become nurse practitioners in New Zealand, candidates earlier needed a Master's Degree (or equivalent), a minimum of four years' experience in a specific area of practice, and they should also have cleared the Nursing Council of New Zealand's Nurse Practitioner Assessment.<sup>xviii</sup> Since 2014, nurse practitioner training in New Zealand also includes the prescribing qualification.<sup>xix</sup>

### **Policy option 2: Post-basic nurse practitioner programme:**

- Botswana started a one-year post-basic family nurse practitioner (FNP) programme to prepare nurses to provide comprehensive primary care services. The course included instructions on how to select drugs for a particular condition.<sup>xx</sup>

### **Policy option 3: Prescriber course:**

- In the UK, registered nurses (RNs) who are not NPs can prescribe independently, but they have to complete an independent/supplementary prescriber training course accredited by the Nursing and Midwifery Council (the course duration is approximately 22 weeks).<sup>xxi</sup> The course equips them to prescribe any medicine within their competency, including medicines listed on the British National Formulary, unlicensed medicines and controlled medicines in schedules 2-5.<sup>xxii</sup>
- In addition to the independent/ supplementary prescriber course, the UK also has a Community Practitioner Nurse Prescribing course accredited by the Nursing and Midwifery Council. Most of the nurses doing the course are district nurses and public health nurses, community nurses and school nurses. They are qualified to prescribe only from the Nurse Prescribers Formulary for Community Practitioners.

### **Policy option 4: Inclusion of prescription related syllabus in nurse education programmes**

- In Spain, the 4-year nursing degree itself includes the required pharmacological training and those who pass out are thus qualified Independent Nurse Prescribers.<sup>xxiv</sup>
- The option proposed represents a combination of three of the above models.
- The Nurse Practitioner in Critical Care (PG/Residency programme) has already been notified by the Indian Nursing Council<sup>xxv</sup> and INC has approved institutes to offer this programme.<sup>xxvi</sup> Educationally, this has already set the course for the NP system in India. Similar post-graduate courses in different specializations should be introduced to expand and bolster the NP system.
- Additionally, prescription-related content should also be included in the educational courses for nurses. Basic understanding of prescription and content relevant to prescription in primary and preventive care should be included in the Bachelor's courses. This assumes significance especially from the point of view of better-equipping nurses in assuming the role of CHPs as per the NMC Act, 2019 and also for taking up the function of Community Health Officers (CHOs) in Health and Wellness Centres.

- For in-service nurses who have already completed their BSc degree and would not benefit from the modified BSc nursing course syllabus, a prescriber education course of about six months on the lines of the UK model can be started.

## Policy recommendations

- Define “Community Health Providers” in the rules for Section 32 of the National Medical Commission Act to include nurses with at least Bachelor’s Degree’s so that nurses can independently prescribe in primary and preventive healthcare.
- Amend the Indian Nursing Council Act, 1947 to enable the advent of prescribing nurse practitioners in India. This would allow nurses with a Masters’ Degree to prescribe independently in secondary care.
- Nurse prescription should be introduced initially for a limited scope of practice and expanded in clearly defined and timed phases.
- Incorporate prescription-related content related to primary and preventive care in the Bachelor’s courses for training nurses, and content relevant to secondary and tertiary care in the Master’s courses of nurse education.
- Similar nurse practitioner courses catering to different specializations should be started in India, on the lines of the Nurse Practitioner in Critical Care (PG/Residency programme) notified by INC.
- For in-service nurses who have completed their nursing degree in the past, it is recommended to start a prescriber education course of six months.

## Implementation considerations

### Education

- **Incorporate clinical internship in the training programme:** In Australia’s NP training programmes, there is a 450 hours Clinical Internship Programme in the NP’s area of specialization, covering advanced clinical skills, diagnostic skills and prescribing skills based on the clinical learning plan developed for the candidate. Clinical case presentations of select patients are used as the methods of assessment. A tool based on the standardized ‘Bondy Scale’ helps to assess the level of independence/ dependence attained by the NP candidates.<sup>xxvii</sup>
- **Tailor chosen qualification model to Indian realities and assess prescribing skills of nurses before granting them prescribing rights:** A survey shows that 61% of all nurse training institutions in India do not meet INC standards.<sup>xxviii</sup> There is therefore a need to scrutinize the prescribing skills of pass-outs of nursing institutes. An examination on the lines of the NEXT (National Exit Test) should be held for those passing out of the BSc nursing course, which gives due weightage to the assessment of prescription-related competencies. INC should also design an examination to test the prescription competencies of nurses with Master’s qualification (on the lines of the pre-2014 system in New Zealand described earlier).

## Regulation

- **Strengthen monitoring of nursing institutes:** The monitoring of the quality of nursing institutes should be strengthened. Since State Nursing Councils have been known to allow sub-par nursing institutes,<sup>xxx</sup> the accountability of State Nursing Councils to the INC should be firmly established.
- **Legislate to protect the title of nurse practitioner:** In countries where the NP system is implemented successfully, there is a legislation to confer and protect the title of “Nurse Practitioner”.<sup>xxx</sup> The Indian Nursing Council should register not only registered nurses (RNs) but also nurse practitioners (NPs) once the educational and legal foundations of the NP programme have been established.

## Formularies and protocols

Provision of algorithms, protocols and guidelines for screening, treatment and drug titration can be valuable resources to guide nurse prescription, given nurses' lesser prescription-related training compared to doctors.

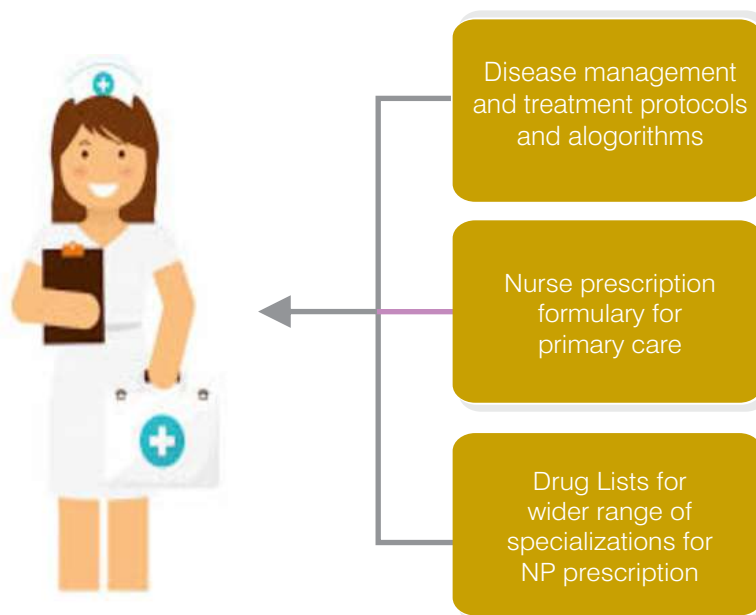


Fig. 6. Implementation considerations to demystify and standardize nurse prescription

## Create detailed algorithms, protocols, and guidelines to simplify prescription

- In Brazil, predetermined protocols specify what drugs can be prescribed by nurses. The protocols are defined by the Policy for Primary Healthcare which was established by the Ministerial Order. Additionally, there are protocols arranged and approved in health institutions.<sup>xxxi</sup>
- In India, standard treatment guidelines/ protocols should be developed for a wide range of communicable and non-communicable diseases on the lines of protocols developed under various national programmes such as the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS).

### **Develop nurse prescription formulary, including for preventive and primary care**

- Some countries have defined formularies from which nurses can prescribe (such as the United Kingdom) whereas others do not have defined formularies (e.g. USA). Countries usually have restrictions on the prescription of controlled substances.
- Independent/supplementary prescribers in the UK can prescribe from the British National Formulary (BNF) to the extent of their competence. The UK also has the Nurse Prescribers Formulary for Community Practitioners (who have passed the Community Practitioner Nurse Prescribing Course). This is a further limited formulary including dressings, the general sales list and 13 prescription-only medicines.
- India should borrow from the UK the above-mentioned idea of a limited formulary for community nurses who practice primary and preventive care. The formulary for nurse prescription in primary and preventive healthcare can be broadly based on the lists specified in the Ayushman Bharat Guidelines for Health and Wellness Centres;<sup>xxxiii</sup> inputs from the Indian Nursing Council should be used to refine the lists for drug prescription.

### **Develop drug lists for NP prescription for a wider range of specializations:**

- In Australia, there are agreed drug formularies for each category of NP practice.<sup>xxxiv</sup> On these lines, INC should develop independent and supplementary prescription lists for a wider range of specializations/ competencies on the lines of what it has done for the Nurse Practitioner in Critical Care (PG- Residency Programme).

## **Stakeholder support strategies**

### **Position the discourse appropriately**

- To obtain the support of medical professions. There is a need to position the discourse in terms of enabling more efficient use of doctor's time to attend to complex cases and avoid deficit language in the discourse. In the UK and Ireland, where the policy intent was related to the efficient use of health professionals' skills and knowledge and improvement of care, the most expansive prescription rights were granted to nurses.<sup>xxxv</sup>

### **Organize a pilot project**

- The Nursing and Midwifery Board of Ireland and the National Council for the Professional Development of Nursing and Midwifery in Ireland carried out 10 pilot site nurse/midwife prescribing projects. These pilot projects played a role in eliciting approval for nurse/midwife prescribing. Similarly, pilots of nurse prescribing in the Indian context may help in generating evidence, which can facilitate stakeholder approval and generate insights to refine policy and implementation design. The pilots thus need to be accompanied by an appropriate evaluation schedule<sup>xxxvi</sup> and agreed criteria of evaluation by independent actors or agencies.

### **Build the capacity of professional nursing associations**

- The professional nursing associations such as the Trained Nurses Association of India (TNAI) should lead the advocacy for nurse prescription rights. The unions/professional associations of nurses have played a critical role in the UK, USA and Ireland which have seen expansive nurse prescription reforms.

The population at large, the media and the political class should be made aware of nurse prescription

- So that they become informed supporters of the approach. In the US State of South Carolina, state-wide coalition building, lobbying and development of personal ties with lawmakers, use of research evidence, and political savviness helped win prescribing rights for APRNs (Advanced Practice Registered Nurses).<sup>xxxvii</sup>

### **Conduct patient awareness campaigns**

- Patients should be made aware of the benefits but also the legal limitations of nurse prescribing so that they don't pressurize nurses to prescribe beyond their scope. In the absence of doctors, patients sometimes demand a prescription from nurses. One paper on India indicates that nurses' perception due to their lack of authority to prescribe medicines in such situations may undermine patients' trust in them.<sup>xxxviii</sup> One commentary suggests general principles of non-medical prescribing for the UK, which state that "Non-medical prescribers must ensure that patients are aware that they are being treated by a non-medical practitioner and of the scope and limits in their prescribing... There may be circumstances where the patient has to be referred to another healthcare professional to access other aspects of their care."<sup>xxxix</sup>

### **Summary of key implementation related suggestions**

- Strengthen the quality and monitoring of nurse education in India, since nursing education is the bedrock of nurse prescribing.
- An examination on the lines of the NEXT (National Exit Test) should be held for those passing out of the BSc nursing course, which gives due weightage to the assessment of prescription-related competencies. INC should also design an examination to test the prescription competencies of nurses with Masters' qualifications.
- Given the widespread prevalence of mediocre nursing institutes, nurse prescription education courses should be piloted in the Centres of Excellence of Nursing Education before the larger universe of institutes takes on their delivery.
- Have multi-site pilot projects (as were done in the UK and Ireland) before introducing nurse prescription on a scale. Such pilots can help generate evidence and approval for nurse prescription and insights for refining policy design.
- Include well-designed clinical internships linked to a standardized assessment of prescribing competencies in education/training courses for nurse prescribers.
- Standard treatment guidelines/ protocols should be developed for a wide range of communicable and non-communicable diseases.
- A limited formulary for community nurses who practice primary and preventive care should be drawn up. The formulary for nurse prescription in primary and preventive healthcare can be broadly based on lists specified in the Ayushman Bharat Guidelines for Health and Wellness Centres.

- The Indian Nursing Council should develop independent and supplementary prescription lists for a wider range of specializations/ competencies on the lines of what it has done for the Nurse Practitioner in Critical Care (PG- Residency Programme).
- Organize patient awareness campaigns for some time and engage patient associations to receive their support in carrying out such campaigns in order to make patients aware of the benefits and legal limitations of nurse prescribing.

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### Contributors and acknowledgements

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## END NOTES

<sup>i</sup>The recommended policy solution for each thematic component in this brief is either one of the policy options presented or a combination of elements from multiple policy options presented.

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<sup>xv</sup>The Medicinal Products: Prescription by Nurses and Others Act, 1992 of UK defines a nurse prescriber as any registered nurse, midwife or health visitor.

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