British Columbia Pharmacy Association
Suite 1530 - 1200 West 73rd Avenue
Vancouver, BC V6P 6G5
Tel: 604 261-2092 Fax: 604 261-2097
info@bcpharmacy.ca www.bcpharmacy.ca

November 2, 2017

Mr. Bob Nakagawa
Registrar
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC V6J 5C6

Dear Bob:

The BC Pharmacy Association thanks the College of Pharmacists of BC for the opportunity to provide comments on the Framework for Pharmacist Prescribing in British Columbia that was revised in September 2017.

The Association represents more than 3,200 pharmacists and more than 900 community pharmacies across British Columbia and works hard to advance and support the professional role and economic viability of our members.

The BCPhA supports allowing pharmacists to initiate prescriptions. In fact, pharmacist expansion of scope reflects the aspiration of B.C. pharmacists, and one of the Association's key goals is: "Pharmacists are able to practice the profession of pharmacy at the highest levels and to its fullest extent."

We appreciate the College's consideration of our feedback on the 2016 draft framework, most noticeably our request for engagement with prescribers. However, the BCPhA remains concerned about the approach the College has now taken in its newly revised draft framework, specifically narrowing pharmacist prescribing to only within collaborative practice and continued restriction of pharmacist prescribers from dispensing the medications for a patient.

1. Narrowing the scope of pharmacist prescribing to within collaborative practice.

As mentioned in our 2016 submission on the first draft framework for the certified pharmacist prescriber initiative, the BCPhA supports pharmacist prescribing. We have advocated for pharmacist prescribing for minor ailments and dispensing the appropriate medications in rural areas. Pharmacists have the authority to treat minor ailments in many provinces in Canada and elsewhere,[i] but not in British Columbia.

A minor ailment is commonly defined as a self-limiting medical condition that will resolve itself on its own and can be reasonably self-diagnosed and managed without medical intervention. It is also generally accepted that lab tests are not needed to diagnose the condition; that treating the condition as a minor ailment will not mask underlying more serious health conditions; that medical and medication histories can reliably differentiate more serious conditions; and that only minimal or short-term follow-up with the patient is necessary. Minor ailments include common conditions like headaches, back pain, insect bites, diaper rash, cold sores, acne, athlete's foot, heartburn or indigestion and nasal congestion.[ii]

What is concerning in the recent draft framework is the notion that pharmacists, in order to prescribe at all, require oversight from physicians or nurse practitioners, who would diagnose and provide access to lab test results. It's no surprise that prescribers' feedback indicates they feel pharmacists should have more supervision from them. The College of Family Physicians of Canada expressed concerns about allowing other health-care professionals to prescribe and recommended a collaborative care model,[iii] and the Canadian Medical Association (CMA) has said more forcefully in

response to Alberta's legislation to allow pharmacists to prescribe, "that pharmacists not be given independent prescribing authority."[iv]

The BCPhA believes this revised framework while trying to assuage concerns from physicians, has gone too far in its limiting of scope for pharmacists. Rather than working toward gaining incremental steps forward for the profession, it has relegated pharmacists into a helper-like position. We recommend the College take a more stepped approach with first asking for pharmacist prescribing for minor ailments. This would help address the long-standing challenges of access to care in rural areas.

The Ministry of Health's 2015 cross-sector policy discussion paper identified the unique challenges B.C. faces in providing appropriate access to health care in rural areas of the province. These ranged from "geographic remoteness, long distances, low population densities, less availability of other providers and inclement weather conditions".[v] People living in remote and rural areas have a lower life expectancy[vi] and face difficulties accessing health services. It is a challenge to attract and retain health care providers in rural areas.[vii]

We take issue with the College's assertation that it is "much more difficult"[viii] for community pharmacists to relay information to family physicians. The College implies in its draft framework that pharmacists would be best to be physically co-located with physicians (in either hospitals or at a doctor's office) to improve patient care. There are examples in British Columbia in which pharmacists have proven they do not need to co-locate in a physician's office or work alongside nurses and doctors at a hospital to create a collaborative team environment and provide excellent patient care.

Nowhere in this revised draft framework does the College address the other key factor in the success of pharmacist prescribing: ensuring payment of the services.

In other Canadian provinces where pharmacists have prescribing authority, but no one willing to pay for it, there is little evidence to demonstrate the value of this for the system or patients. If these services are not paid for, it's unlikely that there would be uptake by a patient, who would pay out of pocket for this expense. Additionally, it would seem there would be no incentive to see a prescribing pharmacist co-located at a family practice and pay a fee when a patient could see a physician, whose services are paid for.

It appears this revised framework addresses hospital pharmacists, who are already co-located in hospitals with prescribers, but leaves little in addressing the important role that more than 3,900 community pharmacists play in delivering patient care in B.C., especially in rural and remote communities, where community pharmacists are often the first point of care and key to continuity of care.

Considering that in rural communities, where there may not even be a family doctor, this plan becomes an even bigger issue for access to care for patients.

2. Restricting certified pharmacist prescribers from dispensing medications they prescribed for a patient.

The BCPhA remains concerned that the College's proposal still excludes pharmacists, and ultimately pharmacist owners, from prescribing and dispensing these medications to a patient because of "a potential business conflict of interest".[ix] At no point have we seen any evidence to show there is an issue.

As we have stated in our past submissions, not allowing pharmacists to prescribe and dispense medications for a patient will impact access to care for patients in rural and remote communities already facing issues of access to care.

There are currently 89 community pharmacies that serve 66 rural-designated communities in BC. Of those 66 communities, 60 per cent have only one pharmacy in town. In these areas, it is not unusual for the only pharmacist on duty to be the owner of the pharmacy, especially since many are independently owned.

A 2015 survey of pharmacists in rural BC, respondents said that more than 80 per cent of their patients would have to travel between one to two hours to access health care. In rural areas 85 per cent of community pharmacies are

independent operators. So, the ban on pharmacist owner prescribers would seem to favour corporate ownership and pharmacies that can have multiple pharmacists on staff at all times and would negatively affect patient care in rural and remote communities.

There is little evidence to support the belief that pharmacist prescribers cannot manage this ethical challenge, while other prescribers, like physicians, dentists, naturopaths, optometrists, who also run health-care businesses can. Based on discussions with other provinces that allow for pharmacist prescribing there have been no reports of such unethical practices by pharmacists.

We know there are always challenges that face all professionals who work for payment. In a health-care environment, it is always the pledge to put a patient's best interests first that drives professional judgement. If regulators of other professionals and in other jurisdictions have not put this requirement in place, we do not understand why the College is proceeding with this approach. The BCPhA asks the College to consider the impact this action will have on the reputation of pharmacists as a self-regulating profession.

If the profession of pharmacists itself does not believe it can adhere to ethical codes of conduct, then putting this requirement in place would be a vote of no confidence in the professionalism of its registrants. We continue to urge the College remove this restriction of pharmacist prescriber not being able to dispense and to monitor the issue of over time. We recommend looking at other ways of how to deal with this ethical challenge, such as strengthening the Conflict of Interest Standards.

B.C. has been a leader in continuing to advance the scope of practice for pharmacists. We believe there are ways to achieve pharmacist prescribing, which will have better health outcomes at optimal costs for patients through the expansion of prescribing for minor ailments.

Sincerely,

Geraldine Vance
Chief Executive Officer, BC Pharmacy Association

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[i] Pharmacists' Expanded Scope of Practice. December 2016. http://www.pharmacists.ca/pharmacy-in-canada/scope-of-practice-canada/

[ii] BC Pharmacy Association submission to the Select Standing Committee on Health. July 2016.

[iii] College of Family Physicians of Canada. (2010, January). Prescribing Rights for Health Professionals [Position Statement].

[iv] Kondro, W. (2007). Canada's doctors assail pharmacist prescribing. Canadian Medical Association Journal, 177(6), 558-558. doi:10.1503/cmaj.071212

[v] British Columbia, Ministry of Health. (2015). *Rural health services in BC a policy framework to provide a system of quality care: Cross sector policy discussion paper*. Victoria, B.C.: Ministry of Health.

[vi] Romanow, R. J. (2002). Building on values: The future of health care in Canada (Commission on the Future of Health Care in Canada.). Saskatoon, Sask.: Commission on the Future of Health Care in Canada.

[vii] Ibid.

[viii] Certified Pharmacist Prescriber: Framework for Pharmacist Prescribing in British Columbia. (2017, September).

[ix] Ibid.