British Columbia
Pharmacy Association

British Columbia Pharmacy Association (BCPhA)

B.C. Rural Pharmacies: Challenges and Recommendations

November 2023

Background

In October 2023, the BC Pharmacy Association (BCPhA) formed a Rural Pharmacy Working Group (RPWG) with pharmacist representatives from rural/remote communities across British Columbia. The purpose of the working group is to identify some of the critical challenges rural/remote pharmacies are continuing to face today and put forward recommendations to ensure equitable access to pharmacy services for residents in these communities.

Between the different eight working group members, they represent 77 pharmacy chains, banners, and independents, located in 71 rural/remote communities including Tofino, Fort Nelson, Port McNeil, Lillooet, Prince George, Salmon Arms, and Quathiaski Cove.

The working group discussed long-standing challenges in rural pharmacy practice and revealed a sense of lack of progress over the past many years. Challenges include, but are not limited to, workforce shortages, difficultly in recruiting and retaining pharmacists and staff, lack of locum/relief support, lack of digital infrastructure, shortage of housing, and no formal mentorship/ education to support new graduates or out-of-province pharmacists considering rural practice. The challenges are interconnected and can negatively impact the quality, accessibility, and sustainability of pharmacy services in rural/remote communities.

While the number of challenges is overwhelming, the group agreed that there are priority recommendations that can initially be put forward to help with the workforce shortage of pharmacists in rural practice. There are many complex factors that affect workforce recruitment and retention, and the group discussed that multiple strategies are required to reduce the barriers to attracting and retaining the rural pharmacist workforce.

Workforce Shortage: Recruitment and Retention challenges

Recruitment and retention of pharmacists is a fundamental priority for sustaining health services in rural/remote communities. As outlined in the BCPhA 2016 submission to the Select Standing Committee on Health, there is little evidence to suggest that the workforce shortage has improved since Health Canada published its 2002 report identifying the need to attract and retain the supply of health care providers in rural areas. It has been found that problems accessing health services quite often stem from shortages in health providers in rural communities.

Data from the Canadian Institute for Health Information (CIHI)[1] showed that between 2012 to 2021, in B.C., there was a 16% overall increase in the number of pharmacists working in rural/remote locations versus a 30% increase in the number of pharmacists working in urban communities. Furthermore, data showed that pharmacy graduates are increasingly turning to hospital rather than community (4.5% vs 2.6%) with the largest percentage increase turning to other places of work such as health-related industries and post-secondary educational institutions (6.6%).

Rural/remote areas often face more significant recruitment challenges than urban centers due to multiple factors including geographical isolation. Coming out of the pandemic, pharmacies across the spectrum from chain to single independent owners are finding it difficult to hire community pharmacists in both urban and remote areas. With so much opportunity, it has become an even greater challenge to entice existing and newly graduated pharmacists to move to rural and/or remote areas to live and work. This lack of adequate staffing can

[1] Canadian Institute for Health Information. Pharmacists. Accessed November 8, 2023.

place undue strain on pharmacy teams who are based in these communities, leading to high workload, poor work-life balance, and decreased job satisfaction, which all contribute to professional burnout. Furthermore, as the government expands the authority and expectations on pharmacists, those working in rural/remote communities are struggling to consistently provide these additional services without the appropriate human health resources.

Business Sustainability

The current pharmacy Rural Incentive Program (RIP) under the framework of the *Pharmaceutical Service Act* (PSA), has not been updated since 2010 and only applies to a small number of pharmacies. In addition, the transition of drug plan coverage from the federal NIHB to the provincial Plan W for First Nations clients, resulted in a significant projected loss for several pharmacies under the RIP in 2017. Furthermore, the flat dispensing fee, effects of generic price reductions and rising inflation have increased the cost pressures on rural pharmacies.

Pharmacy operators in rural communities are coming under increasing financial strain due to higher operating costs, due in large part from higher staff wages (Table 1) compared to urban counterparts, higher costs of recruitment and retention, as well as the increased cost to service the smaller communities due to transportation and delivery of medications. The current RIP does not adequately address the costs associated with rural pharmacy practice and needs to be revisited.

Table 1. Hourly Wage for Full Time Pharmacists

Region	Average Hourly wage	% of Respondents
Cariboo, Peace River, Prince George, Burns Lake	$63.64	4.2%
Fraser River north (includes Sunshine Coast, North Vancouver, West Vancouver, Burnaby, New Westminster, Port Moody, Coquitlam, and Port Coquitlam).	$53.09	12.9%
Fraser Valley (includes Surrey, North Delta, Langley, Aldergrove, Abbotsford, Chilliwack, White Rock, Maple Ridge, Mission, and Pitt Meadows).	$52.22	24.3%
Greater Victoria and the Gulf Islands.	$58.06	6.8%
Kootenay, excluding Golden and Revelstoke.	$60.71	2.7%
Richmond, South Delta (includes Tsawwassen and Ladner).	$51.67	3.4%
Skeena, Houston, Smithers, Terrace, Kitimat and Prince Rupert.	$65.75	1.5%
The City of Vancouver, including UBC.	$49.29	18.3%
Thompson Okanagan (includes Lytton, Lillooet, Golden, Revelstoke, Barriere and Clearwater).	$59.89	13.3%
Vancouver Island, including Powell River.	$58.82	12.5%

Source: 2023 BCPhA Wage and Benefit Survey

Professional Development

Professional development is essential as part of a pharmacist's commitment to lifelong learning, maintenance of knowledge, skill enhancement and career growth specific. Professional development opportunities include participating in local community health initiatives, collaborating with other health organizations, and providing quality improvement and health promotion programs in communities. Members of the working group and

particularly pharmacist owner/operators felt that those working in rural or remote communities have more barriers to accessing professional development due to limited local learning opportunities, travel costs and challenges in hiring locums to cover shifts to attend and/or provide community health events to patients. This reduces the opportunity to network, connect and integrate with local community members, peers, and mentors.

Recommendations

The BCPhA outlines the following priority recommendations to help address the challenges in rural pharmacy workforce, business sustainability and professional development:

1.	Establish an appropriate and consistent eligibility criteria for a "rural/remote community pharmacy" in B.C.
2.	Integrate community pharmacists into the provincial rural health-care planning strategy and establish a committee on rural pharmacy issues to ensure communities have adequate access to pharmacy services.
3.	Develop recruitment incentive programs to attract pharmacists to longer-term pharmacy positions in rural communities.
4.	Incentivize pharmacy graduates to practice rural pharmacy by developing a student loan forgiveness program and a rural bursary undergraduate program.
5.	Develop a rural locum funding program to support pharmacists in their efforts to attract locums and subsidize locums for temporary absences (e.g., vacation relief, professional development opportunities, health reasons).
6.	Modernize the pharmacy Rural Incentive Program (RIP) to support pharmacy sustainability in all rural/remote areas in B.C.
7.	Develop funding to support rural pharmacists professional development and collaborative local health solutions.
8.	Allow increased use of virtual telepharmacy services to support patient access to pharmacy services in remote communities.

Recommendation 1: Establish an appropriate and consistent eligibility criteria for a "rural/remote community pharmacy" in B.C.

Statistics Canada defines rural areas to include territories lying outside population centres (i.e., urban areas) with population concentrations and densities below a certain threshold.[2] Furthermore, they have developed an index of remoteness[3] that ranges from "0 least remote" (e.g., Vancouver index 0.06) to "1 most remote" (e.g., Fort Nelson index 0.55) rated for every municipality in Canada. Remoteness is an important determinant of socioeconomic and health outcomes and is consequently an essential indicator for delivery of policies and programs.[4]

Under the physician Rural Practice Subsidiary Program (RSA), the Joint Standing Committee (JSC) has determined which community is designated rural/remote based on their geographical remoteness factor and medical isolation points. Physicians practicing in these communities are eligible for certain rural practice incentive

[2] Statistics Canada. Rural area (RA). Updated: February 9, 2022.
[3] Statistics Canada. Index of Remoteness. Updated: January 4, 2023.
[4] Statistics Canada. Population growth in Canada's rural areas 2016 to 2021. Release February 9, 2022.

programs. The Rural Coordination Centre of British Columbia (RCCbc) has developed a map of these rural communities which spans over 200 communities in the province.[5]

The BCPhA recommends that the Ministry adopt the same rural/remote community designations as the RSA or develop a similar designation system for communities and the pharmacies that practice within those communities to recognize the unique opportunities and challenges encountered in delivering pharmacy services in these areas.

Recommendation 2: Integrate community pharmacists into the provincial rural health-care planning strategy and establish a committee on rural pharmacy issues to ensure communities have adequate access to pharmacy services.

In 2001, the Joint Standing Committee (JSC) on rural issues was established to develop strategies to look at the challenges associated with providing physician services to rural communities in B.C. and they created the Rural Practice Subsidiary Agreement (RSA) to address these challenges. The JSC is comprised of the Doctors of B.C., the Ministry of Health, and Health Authorities. Pharmacists are an essential and integral part of the health-care system and play an even more pronounced role in many rural/remote communities, yet there is currently no structured mechanism for government, community pharmacists, and other stakeholders to specifically address rural pharmacy issues.

Integrating community pharmacists into the government's health-care planning for rural communities is essential. B.C. pharmacists call on the Ministry of Health to formally integrate community pharmacists into its official stakeholder engagement process, add community pharmacy representation to its rural health-care planning teams and establish a committee to specifically address rural pharmacy issues.

Recommendation 3: Develop recruitment incentive programs to attract pharmacists to longer-term pharmacy positions.

Terry et al 2021[6] carried out a systematic review to identify factors associated with recruitment and retention of pharmacist workforce in rural/remote settings and effective interventional strategies to help resolve pharmacist workforce shortages. They concluded that financial rewards were considered positive factors, which comprised of a higher income or salary and financial incentives and other benefits, including funding support from the government, specific remuneration packages and other contractual agreements.

(a) Financial incentive

Under the physician Rural Practice Subsidiary Agreement (RSA), the Recruitment Incentive Fund (RIF), managed by the Ministry of Health, provides recruited physicians a one-time financial incentive to fill current or pending vacancies in eligible RSA communities, ranging from $5k to $20k depending on the ranking of the RSA community (A, B, C, or D). Communities ranked "A" are the most isolated and where physicians receive the highest incentives. A physician is obligated to repay this benefit if they leave the community within one year of their start date.

[5] Rural Coordination Centre of BC. Map of Rural Communities.
[6] Terry, D., Phan, H., Peck, B. et al. Factors contributing to the recruitment and retention of rural pharmacist workforce: a systematic review. BMC Health Serv Res 21, 1052 (2021). https://doi.org/10.1186/s12913-021-07072-1

Currently, pharmacist owners/operators are paying out of pocket to incentivize applicants to their community which adds to the financial constraint in a pharmacy that already has higher operation costs. As well, with the current demand for pharmacists in both urban and rural communities, rural pharmacies are challenged in competing against positions in urban centers leaving a very small pool of pharmacists willing to work in rural communities.

Introducing a rural recruitment incentive program funded by the government will provide pharmacies with a robust support system to attract pharmacists, especially those in the most isolated communities. The amount of incentive can be based on an established eligibility criteria and on a tiered system depending on the community's level of isolation similar to that of the physician's RSA community designation.

(b) Recruitment contingency fund (housing and relocation incentives)

The working group expressed that recruitment agencies are very expensive, and the recruitment process is a "full-time job" due to the amount of administrative work in attracting and relocating qualified individuals into rural practice. Physicians in RSA communities can apply for funds to cover recruitment expenses, including relocation costs (up to $25,000 per position) under the physician Recruitment Contingency Fund. This is provided annually to assist eligible communities with recruiting expenses (e.g., advertising, travel, food, moving logistics, and housing support such as temporary accommodation, and rental costs).

Developing a similar funding model to that of physicians, which includes a relocation package for pharmacists, can help offset the additional costs associated with attracting and relocating a pharmacist to a rural area. A relocation package would support pharmacists, including international pharmacy graduates (IPGs), considering rural practice but may be hesitant to relocate due to challenges associated with moving to remote communities. Data[7] show that international graduates accounted for approximately 34% of the overall pharmacists in B.C. in 2021. A relocation package should be flexible to address the specific needs of the pharmacist relocating.

A new initiative in Fort Nelson was implemented in 2021 which provides direct incentives to pharmacists and other eligible health-care professionals to work and reside in the Northern Rockies. This program includes a one-time or escalating financial incentives in addition to transportation, housing and settlement supports.[8] For example, pharmacists can apply for housing incentives which would fully cover the cost of their residential accommodation (market rent and utilities) for the first 6 months and then at 50% during the second 6 months.[9] This would help address rural communities such as Tofino that services multiple offshore First Nations communities but have a lack of affordable housing which prevents applicants moving to the area.

[7] Canadian Institute for Health Information (CIHI). Pharmacists. Accessed November 8,2023
[8] Northern Rockies Shows Leadership in Health Recruitment October 5, 2022, Media Release.
[9] NORTHERN ROCKIES Recruitment & Retention Education & Training Incentive (RRETI) Program.

<u>Recommendation 4</u>: Incentivize pharmacy graduates to practice rural pharmacy by developing a student loan forgiveness program and a rural bursary undergraduate program.

UBC Faculty of Pharmaceutical Sciences noted there is very limited information tracking the employment location of alumni in a systematic way for privacy reasons. However, Pearson et al.[10] conducted a study on the job location decision of the 2007 graduating pharmacy class at UBC. Findings showed that the majority of graduates coming from rural/remote communities did not return to their hometown, mostly taking jobs in larger communities, primarily in Metro Vancouver. Those who did take jobs in rural/remote communities had come from these communities; many took jobs in their home region but not necessarily in their hometown. This finding aligns with that found in the Terry et. al 2021[11] systematic review which looked at factors contributing to the recruitment and retention of the rural pharmacist workforce. The RPWG shared that in their experience, the average turnover for new graduates is a few months to a year. Those who stayed longer term in rural communities tend to have grown up in rural/remote areas.

To support the recruitment of new graduates, the group discussed strategies including a student loan forgiveness program and a rural bursary program as well the importance of a collaborative approach with UBC (including the Canadian Pharmacy Practice Program (CP3) program IPGs) to raise awareness about and to encourage rural practice experience.

(a) Student loan forgiveness program

The group noted that an increasing number of graduates are moving to other areas of practice such as in hospital, industry, and government places of employment. There are currently no incentives for new graduates to work in rural pharmacy nor to attract them to work for extended periods. Student loans can be a significant deterrent for recent pharmacy graduates considering rural practice. Establishing a student loan forgiveness program can help encourage new pharmacists to work in rural areas where they might be hesitant to practice due to financial constraints. A loan forgiveness program would provide financial relief by reducing or eliminating a portion of their student loan based on their commitment to serving in rural areas. It would be tied to a minimum service commitment period and could be provided in a similar approach to that outlined in the B.C. loan forgiveness program (StudentAid BC) where a rate of up to maximum 20% per year for up to five years will be forgiven. Therefore, if all five years of employment have been completed in an underserved community, all or a percentage of the B.C. student loan debt is forgiven. This would encourage pharmacy graduates to work in rural practice for an extended duration of time.

(b) Rural bursary program for undergraduate students

A Terry et. al 2021[11] study highlighted that increased rural experience and exposure through education and training (e.g., rural teaching and learning sites) have been suggested as effective strategies in improving recruitment and retention of the health-care workforce, including pharmacists.

[10] Pearson ML, Andres L. Job location decisions of pharmacy graduates in British Columbia. Am J Pharm Educ. 2010 May 12;74(4):74. doi: 10.5688/aj740474. PMID: 20585436; PMCID: PMC2879126.
[11] Terry, D., Phan, H., Peck, B. et al. Factors contributing to the recruitment and retention of rural pharmacist workforce: a systematic review. BMC Health Serv Res 21, 1052 (2021). https://doi.org/10.1186/s12913-021-07072-1

A rural bursary program specifically designed for undergraduates could encourage and increase early and repeated exposure to rural pharmacy practice. The bursary program could offer a financial award to undertake the majority of their practicums in designated rural communities to encourage exposure to the real-world dynamics of rural practices and remove the potential increased cost of living expenses of undertaking these practicums. Furthermore, opportunities could be explored to match these award winners with mentorship and training by experienced pharmacists in rural practice to further encourage these students to practice in these communities.

By providing these collective supports, it will help increase the exposure of rural practice to Entry-to-Practice (E2P) PharmD students throughout their program to help foster the belief of a fulfilling career in rural pharmacy.

Recommendation 5: Develop a rural locum funding program to support pharmacists in their efforts to attract locums and subsidize locums for temporary absences (e.g., vacation relief, professional development opportunities, health reasons).

The working group highlighted that one of the most common barriers in rural pharmacy was limited access to, and the availability of, locum pharmacists to cover periods of leave. Community pharmacists need to attract qualified locums on a regular basis which takes an invested amount of time. A pharmacy chain may have the same internal group of locums. However, the working group discussed there is only a limited pool of reliable locums, and they are not always available. It is normal in many situations that if they are unable to find a locum, pharmacist owners/managers may either work extra hours to cover the staff shortage, close the store or reduce the hours of their operation (e.g., shorter business days or closed weekends). One chain described the significant impact on the rural community when they had to reduce their hours and the local hospital lodged a complaint to the College of Pharmacists of B.C. at that time.

To support physicians in the recruitment of locums, Locums for Rural BC (LRBC), funded by the Ministry, assists locum requests by hosting an interactive website (e.g., job postings) for host physicians and locum opportunities and also support travel arrangements. Funding to provide a similar centralized system (e.g., one-stop website, to attract locums to work in rural pharmacies) will greatly help reduce the administrative time to find a locum.

LRBC also manages the Rural GP Locum Program (RGPLP) which assists GPs in rural communities with 7 or less physicians to obtain subsidized locums for vacation relief, continuing education events and health reasons. LRBC arranges assignments for locums who work as independent contractors with the program. The locums are paid a daily rate for provision of services through MSP and are paid a travel time honorarium and travel expenses. Each request must be at least five days in duration (or three days if it is for a weekend) for a regular locum assignment. A similar model to fully support and assist with locum/ relief placements, would give host pharmacists a peace of mind that the pharmacy can remain operational, continue to maintain, and provide access to its service without disruptions. This supports pharmacists to achieve a work-life balance, prevent burnout, allow flexible schedules, and attend professional development opportunities and community engagements. Collectively, this encourages pharmacists to commit to working long-term in rural practice.

Recommendation 6: Modernize the pharmacy Rural Incentive Program (RIP) to support pharmacy sustainability in all rural/remote areas in B.C.

In 2021, there were approximately 335 pharmacists in rural practice.[12] PharmaCare Trends showed that a total of $1.38 million in Rural Incentive Program (RIP) funds was invested in 2021/22[13], which was the lowest since at least 2016. In 2022, there were approximately 865 physicians in rural practice, and the Government provided $60.8 million in annual funding for the RSA Funded Rural Programs.[14] [15] Not only are community pharmacies the cornerstone of rural communities, ensuring consistent access to medication, but they also play a more integrated and active role in smaller communities. Rural pharmacists work collaboratively with other health-care providers to ensure coordinated and comprehensive patient care. As well, they are the primary access points for a growing range of health-care services such as minor ailments and contraceptive services (MACS), drug administration and other clinical services. Therefore, it is imperative that a greater investment is provided to ensure the sustainability in rural pharmacy practice.

Unlike the physician's Rural Retention Program (RRP) eligibility criteria which is based on a point system, the PharmaCare Rural Incentive Program (RIP) eligibility is based on a restrictive "all or nothing" criteria. To qualify, the pharmacy must be the only one in the community, the next nearest pharmacy is more than 25 km away or requires a ferry, and the number of PharmaCare claims must not exceed 1,700 per month. Therefore, only a small number of rural/remote pharmacies qualify for the RIP. The RIP subsidies are calculated on a sliding scale from $3 to $10.50 per claim. Pharmacies with lower monthly PharmaCare claim volumes receive a larger subsidy for each claim. Therefore, the more claims there are per month, the per-claim amount decreases. If there is one extra claim more than 1,700 the pharmacy automatically receives zero subsidizes that month.

Although the RIP is beneficial to a small number of pharmacies, the group agreed that the program, which was last reviewed in 2010, needs to be re-examined. The BCPhA requests that the RIP eligibility criteria be modernized to account for the higher costs of operating in rural communities including significantly higher pharmacist wages, transportation expenses of medication deliveries, maintaining extended hours to ensure patient access to pharmacy services, and having to stock larger inventories of medications due to limited access to health-care facilities and less/infrequent shipments from wholesalers. The RIP criteria should not be an all or nothing approach but based on a point system depending on the community isolation factor.

There are currently 205 designated rural communities under the physician Rural Retention Program (RRP), where practicing physicians are eligible to receive financial retention incentives. These communities are ranked into groups (A, B, C and D) based on the number of isolation points they receive. The more isolated the community, the higher the points. Physicians working in ranked "A" communities receive the highest level of incentive.

Retention benefits paid to physicians includes an annual flat retention fee, a fee premium (percentage paid on top of MSP billings or service contract) and an enhancement fee to the annual flat retention fee to support business costs of physicians who reside and practice in RSA communities.

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[12] Canadian Institute for Health Information. Pharmacists. Accessed November 8, 2023.
[13] Pharmacare Trends 2021/22. June 28,2023. Health Sector Information, Analysis and Reporting Division for Pharmaceutical, Laboratory and Blood Services Division.
[14] Canadian Institute for Health Information. Physicians. Accessed November 8, 2023.
[15] 2022 Rural Practice Subsidiary Agreement

There is currently a total of 318 community pharmacies (**Appendix A**) located within 86 communities that have been designated under the RSA, of which 43 communities have been ranked "A" (Table 2). Within those ranked "A" communities, there are 114 community pharmacies (e.g., in Ashcroft, Burns Lake, Fraser Lake). There should be alignment in the rural incentive/retention program eligibility criteria for both pharmacists and physicians since they are practicing within the same community environment with common geographical and remoteness factors and experience similar rural challenges. The RRP criteria would increase the number of community pharmacies to be eligible for subsidizes.

Table 2. Number of community pharmacies in RSA designated communities

RSA Community Designation	# of RSA communities	# of RSA communities where pharmacies are located	# of pharmacies
A	144	43	114
B	24	11	54
C	35	30	147
D	2	2	3
Total (as of April 2023)	**205**	**86**	**318**

*List extracted August 3, 2023

Recommendation 7: Develop funding to support rural pharmacists professional development and collaborative local health solutions.

The group shared that in addition to financial strategies to help attract pharmacists to rural areas, other strategies are also required to ensure access to high quality pharmacy services. A common challenge experienced by pharmacists in rural practice is the increased costs to attend professional development opportunities. Funding for professional development/continuing education would support ensuring that rural pharmacists are not disadvantaged in their efforts to enhance their knowledge and skills in line with the urban counterparts. As well, funding should be considered to support pharmacists in the development and participation in collaborative local health-care initiatives. It is common that pharmacies in rural communities often in partnership with other health-care providers develop unique solutions to address health-care access issues as a result of geographic and human resource challenges.

Professional development opportunities may include:

- Continuing education conferences, workshops, and online courses relevant to their practice (e.g., cultural safety training, trauma-informed care, clinical training programs).
- Collaboration with local physicians and other health-care providers (e.g., participation in quality improvement programs and initiatives/ special projects to improve health-care access.

Currently no such funding mechanism exists for pharmacists, unlike for physicians where they have the ability to apply for professional development opportunities under the Rural Continuing Medical Education Program (RCME) established by the JSC. The program provides individual support directly to eligible physicians, for example covering the overhead expenses to attend medical education, enhance skills and credentials for rural practice as well as funding and resources to groups of local physicians in community education needs (e.g.,

course fees, instructor fees, room rentals, catering, purchasing new technology or equipment to participate in CE activities).

Other programs that support rural physician training and education include Rural Education Action Plan (REAP), managed by UBC and the Rural Coordination Centre of BC (RCCbc), led by rural physicians which co-develops education and mentorship opportunities including advancing rural skills and leadership development.

Recommendation 8: Allow increased use of virtual telepharmacy services to support patient access to pharmacy services in remote communities.

(a) Virtual pharmacist supervision

Due to workforce shortage in rural pharmacies, some may have had to reduce their hours of operation which significantly impacts the continuity of care. This is particularly felt in communities with only one or two pharmacies. Pharmacies in urban centres tend to have the capacity to remain operational for longer hours such as during evenings and on weekends. The group discussed remote virtual supervision whereby pharmacists at the urban location (central site) could directly supervise all activities at the rural site, operated by a pharmacy technician via audio video conferencing technology. This is similar to the community telepharmacy model.

There are currently 11 licensed telepharmacies in B.C. in such locations as Logan Lake, Granisle and Gold River and more. To be licensed as a community telepharmacy, the College of Pharmacist of B.C. eligibility criteria include that the telepharmacy must be the only pharmacy in the community and that the next closest telepharmacy or community pharmacy must be at least 25 km away. Expanding the criteria to allow real-time digital pharmacist supervision in rural pharmacies that do not have a telepharmacy license and cannot recruit a pharmacist will allow them to maintain and/or extend their hours of operation or remain accessible during an emergency or unforeseen circumstance (for example a medical leave or illness) and when a locum is unavailable.

(b) Virtual pharmacy-client care

The COVID-19 pandemic has demonstrated the value of virtually delivered health-care services for people living in rural communities. Physicians and other health-care providers have increased their use of virtual care and telehealth during the pandemic to ensure continuity of care. Expanding clinical service fees to allow pharmacies to provide services via virtual care such as minor ailment and contraception services (MACS) will provide timely pharmacy access to residents who cannot travel due to long distances like those who reside in offshore communities. Other pharmacy services that could be provided virtually include medication reviews and follow-up, such as with opioid agonist treatment and other chronic conditions.

Integrating digital technologies into rural pharmacy will provide them with the opportunity to improve patient access to services and overcome geographical challenges. This means an improvement in overall health-care outcomes for patients in these communities.

Conclusion

Although rural pharmacies may provide their own incentives to recruit pharmacists into their communities, the group agreed that no single approach will overcome the ongoing workforce shortage. Developing a diverse range of incentives funded by the Government would create a more cohesive, effective, and equitable approach to

recruiting and retaining pharmacists in all rural/remote communities. Incentives should be developed in a way to support both existing pharmacies *and* pharmacists as well as establish new opportunities for graduates and out-of-province pharmacists.

With pharmacists' scope of practice expanding such as in drug administration, opioid agonist treatment, other chronic disease management, and minor ailment and contraception services (MACS), it is critical that people in rural/remote communities can equitably access these fundamental services.

The BCPhA has highlighted the essential need for multifaceted strategies to help overcome the rural pharmacist workforce challenges that will, in turn, lead to improved patient access to pharmacy services in rural and remote communities.

Appendix A. Number of community pharmacies in designated RSA communities

Health Authority	Community	RSA Community Designation	Number of community pharmacies
IHA	100 Mile House	A	**3**
VIHA	Alert Bay / Namgis First Nation	A	**1**
IHA	Ashcroft / Cache Creek / Ashcroft Indian Band / Bonaparte Indian Band / Oregon Jack Creek Indian Band	A	**6**
NHA	Burns Lake / Francois Lake	A	**2**
NHA	Chetwynd / Saulteau / Saulteau First Nations	A	**2**
IHA	Clearwater	A	**1**
IHA	Cranbrook / ?aq'am (St. Mary's)	A	**8**
IHA	Creston / Lower Kootenay Band	A	**4**
NHA	Dawson Creek	A	**7**
IHA	Elkford	A	**1**
IHA	Fernie	A	**3**
NHA	Fort Nelson / Fort Nelson First Nation	A	**2**
NHA	Fort St. James / Binche	A	**2**
NHA	Fort St. John / Taylor	A	**7**
NHA	Fraser Lake	A	**1**
IHA	Golden	A	**2**
IHA	Grand Forks	A	**2**
IHA	Greenwood / **Midway** / Rock Creek	A	**1**
NHA	Hazelton / Gitanmaax Band / Glen Vowell (Sik-e-Dakh) / Hagwilget Village (Tse-kya) / Kispiox Band (Anspayaxw)	A	**1**
NHA	Houston	A	**1**
IHA	Invermere / Windermere / ?Akisq'nuk (Akisqnuk) / Shuswap Band	A	**2**
IHA	Kaslo	A	**1**
IHA	Kimberley	A	**3**
NHA	Kitimat	A	**3**
IHA	Lytton / Lytton First Nation / Kanaka Bar (T'eqt''aqtn'mux) / Nicomen Indian Band / Siska Indian Band / Skuppah Indian Band	A	**1**
NHA	Mackenzie	A	**1**
IHA	Nakusp	A	**1**
IHA	New Denver	A	**1**
VIHA	Port Hardy / Gwa'sala-Nakwazda'xw / Kwakiutl First Nation (Kwakwaka'wakw) / Tlatlasikwala First Nation	A	**2**
VIHA	Port McNeill	A	**1**
NHA	Prince Rupert	A	**5**

IHA	Princeton	A	**2**
NHA	Quesnel	A	**7**
IHA	Revelstoke	A	**2**
IHA	Salmo	A	**1**
NHA	Smithers	A	**4**
VIHA	Sointula	A	**4**
IHA	Sparwood	A	**2**
NHA	Terrace / Kitselas First Nation / Kitsumkalum Band	A	**6**
VIHA	Tofino /Tla-O-Qui-Aht First Nations	A	**2**
NHA	Tumbler Ridge	A	**1**
VIHA	Ucluelet / Macoah / Toquaht Nation / Ucluelet First Nation (Yuułuʔiɬʔatḥ)	A	**2**
NHA	Vanderhoof	A	**3**
IHA	Barriere / Simpcw First Nation / Whispering Pines Indian Band (Clinton Indian Band)	B	**1**
IHA	Castlegar	B	**5**
IHA	**Chase** / **Scotch Creek** / Adams Lake Indian Band / Anglemont / Little Shuswap Indian Band / Neskonlith Indian Band	B	**2**
IHA	Lillooet / Bridge River / Cayoose Creek Indian Band (Sekw'el'was) / Lillooet Indian Band (T'it'q'et) / Xaxli'p First Nation / Xwisten	B	**2**
IHA	Merritt / Coldwater Indian Band / Lower Nicola Indian Band / Upper Nicola Band	B	**3**
IHA	Nelson	B	**6**
VIHA	Pender Island	B	**1**
NHA	Prince George / Lheidli Tènneh Nation	B	**21**
IHA	Sun Peaks	B	**1**
IHA	Trail / Rossland / Fruitvale	B	**6**
IHA	Williams Lake / Soda Creek Indian Band (Xatsull First Nation)	B	**6**
FHA	Agassiz / Harrison / Seabird Island Band	C	**4**
VCHA	Bowen Island	C	**1**
VIHA	Campbell River / Campbell River Indian Band (Wei Wai Kum) / Dzawada'enuxw First Nation / Homalco First Nation	C	**13**
VIHA	Chemainus / Halalt First Nation / Lyackson First Nation	C	**3**
VIHA	Cobble Hill	C	**2**
VIHA	**Courtenay** / **Comox** / **Cumberland** / K'ómoks First Nation	C	**20**
VIHA	Duncan / N. Cowichan / Cowichan Band	C	**15**
IHA	Enderby / Splatsin Tsm7aksaltn	C	**2**
VIHA	Gabriola Island	C	**1**
FHA	Hope / Chawathil / Peters First Nation / Shxw'Ow'Hamel First Nation / Skawahlook First Nation (Sq'ewá:lxw) / Union Bar Road / Yale	C	**3**
IHA	Keremeos	C	**2**
VIHA	Ladysmith	C	**4**
VIHA	Lake Cowichan / Lake Cowichan First Nation	C	**2**
IHA	Logan Lake	C	**1**
VCHA	Madeira Park	C	**1**
VIHA	Mill Bay	C	**2**
IHA	Oliver	C	**3**
IHA	Osoyoos	C	**2**
VIHA	**Parksville** / **Qualicum** / Qualicum First Nation	C	**15**
VCHA	Pemberton	C	**1**
VIHA	Port Alberni	C	**10**
VCHA	Powell River	C	**7**
IHA	Salmon Arm	C	**7**
VIHA	Saltspring Island	C	**3**
VCHA	Schelt/ Gibsons	C	**10**
VIHA	Shawnigan Lake	C	**1**

IHA	Sicamous	C	**1**
IHA	Sorrento	C	**1**
VCHA	Squamish / Squamish First Nation	C	**6**
VCHA	Whistler	C	**4**
IHA	Armstrong / Spallumcheen	D	**2**
IHA	Lumby	D	**1**
	Total number of pharmacies		**318**
	Total number of communities		**86**