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ASSOCIATION

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DU CANADA

**Submission to the Standing Senate Committee on Social**

**Affairs, Science and Technology**

**Health Care Delivery, Optimizing Drug Therapy and the**

**Role of the Pharmacist**

**Presented by:**

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**Canadian Pharmacists Association**

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**The Canadian Pharmacists Association (CPhA) is the national professional voluntary association providing leadership to pharmacists in all areas of practice. Our members are active in community and hospital pharmacies, in long term care facilities, home care, academia and industry.**

## **Presentation to the Senate Committee on Social Affairs, Science and Technology**

The Canadian Pharmacists Association (CPhA) thanks the Committee Chair and members for giving us the opportunity to contribute to your deliberations on some of the most pressing issues faced by Canadians today. Pharmacists as a profession are united in their commitment to play an integral part in the way Canada resolves its health care challenges. We are also committed to taking a “made in Canada” approach to these issues. This approach recognizes our country’s world leadership as it strives to provide comprehensive public health to all its citizens for whom drug therapies are becoming a very prevalent form of care. Such an approach would build upon the firm foundation provided by the Canada Health Act and the health care system it upholds.

Pharmacists are the most easily accessible primary health care providers in Canada; they are found on every main street and many are open extended hours to better serve their communities. Pharmacists have at least 5 years university education and some of the most stringent requirements for the maintenance of professional competency after licensure. They are well integrated into their communities, and successive consumer surveys indicate that they are trusted and valued as health care providers<sup>1</sup>. Pharmacists make substantial contributions to primary health care daily through promoting optimal drug use, the management of minor illness, and health promotion<sup>2</sup>. However, it is also a fact that the knowledge and skills of pharmacists are underutilized on the whole and this reality underlies our entire discussion today.

In this brief we will focus on three key issues that as the national pharmacists association we have actively grappled with over the last 10 years. These are:

- escalating drug costs
- the promotion of optimal drug therapy and drug use, and
- access to drug benefits

Let us briefly summarize what we have seen develop over the past 10 years.

In the early nineties expenditures in public drug plans were increasing in large percentages annually. In 1990 and 1991 average percentage increases were 13.8% and

13.2% respectively, several times greater than the rate of inflation<sup>3</sup>. This resulted in a number of government initiatives. Federally we saw growth in importance of the role of the Patented Medicine Prices Review Board (PMPRB) as a source of price control on new products. Attempts to improve federal/provincial collaboration such as the Canadian Agency for Pharmaceutical Information Assessment (CAPIA), and more recently the National Pharmaceutical Strategy were made. Unfortunately, apart from PMPRB, these strategies have had little impact. Perhaps greater success will result from the announcements in the First Ministers' Communiqué on Health<sup>4</sup>.

At the provincial level, several new strategies emerged<sup>5</sup>. These included:

- De-listing of drugs as benefits (e.g., sustained release formulations).
- Increased cost-sharing through the introduction of, or increases in, co-pays and deductibles (the recent paper by Tamblyn<sup>6</sup> on the experience in Quebec is important evidence on the negative impact of such policies on the use of essential drugs).
- Greater control on new product entry through formulary procedures based on clinical and pharmacoeconomic data.
- Further promotion of generic substitution or incentives to use the least expensive drugs, through strategies such as reference-based pricing.
- Introduction of barriers to access to pharmaceuticals through special authorizations where, usually for an expensive new drug, physicians are required to complete additional forms to support a patient receiving payment.
- Caps or controls on pharmacists fees.

As a consequence, by the mid nineties costs were being shifted to private sector drug plans or to individuals, and we saw the private sector begin to seek methods to control their drug costs<sup>7</sup>. Some examples included experiments with mail order pharmacy, preferred provider organization models with capped fees for pharmacists, or restriction of benefits for smoking cessation products or nonprescription drugs.

To address these issues in the private sector, we brought together provincial and other national pharmacy organizations to form the National Pharmacy Coalition on Managed Care (NPCMC). Set up in 1995, this group addressed the need to control drug expenditures and promote better drug use in the private sector. Recommendations by

NPCMC are laid out in publications such as the “Pharmacists As Key Partners in Drug Plan Management”<sup>8</sup>, and include drug use management strategies such as: generic substitution, trial prescription programs, therapeutic interchange, compliance programs, drug treatment protocols, and drug regimen review.

While the mid nineties saw some attenuation of growth in public sector drug expenditures, this was short lived. (For example, growth rates in 1993 and 1994 were 2.5% and 0.2% respectively). By 2000, estimates for annual increases were back into double digits (12.2%).<sup>9</sup>

In addition to concerns about escalating drug costs, there are also concerns about the quality of drug prescribing and drug use. These have focussed on inappropriate drug selection. The proposed remedy has been prescribing guidelines using an evidence-based medicine approach. Another major concern has been patient noncompliance with prescribed regimens. The remedy has been improved patient education and compliance programs developed by the pharmaceutical industry and implemented in practice by pharmacists. Reports of waste are perhaps the chief indicators of inappropriate prescribing and compliance problems.<sup>10-13</sup> Inadequate information to support prescribing decisions by physicians has also been a concern. CPhA and the Canadian Medical Association have responded by producing handbooks for physicians written by therapeutic experts to assist in prescribing decisions.<sup>14,15</sup> As the new policies began to take hold, several flaws became apparent. First, many citizens have been denied access to basic drug therapy through lack of a drug plan. Second, quality of drug prescribing and drug use remains an issue. And third, a growing population are opting out of traditional health care and turning to alternative therapies, many of which are unproven and unregulated.

Against this background we saw the emergence of calls for a national pharmacare program, with integration of the existing public and private sector plans. This was echoed in the report of the National Forum on Health<sup>16</sup>, given political life by the Liberals in the first red book<sup>17</sup>, and brought to realization in Quebec with the introduction of a universal drug plan, integrating public and private sectors in 1996<sup>18</sup>.

As an Association we saw this as a very significant public policy development, and brought provincial and national pharmacy organizations together in the Canadian Pharmacy Coalition on Pharmacare. This led to the discussion document appended to this brief in which we examine approaches to building a national pharmacare plan<sup>19</sup>. At this point let me say unequivocally that we need national pharmacare more than ever. I will come to the reasons why later. But for now, I will highlight some key findings from our paper.

These are what we see as the four cornerstones of national pharmacare, and emphasize that to succeed, all four cornerstones need to be in place:

**Cornerstone 1: Establish guiding goals and principles**

These should include the Canada Health Act principles of public administration, comprehensiveness, universality, portability, and accessibility. Consideration should be given to adding three more: affordability, effectiveness and efficiency.

**Cornerstone 2: Involve key stakeholders**

Share responsibility between patients, pharmacists, other health care providers and the private sector. Use the pharmacists' knowledge and skill to bring cost benefit to the program. Patients as well as physicians must be better educated and take greater responsibility.

**Cornerstone 3: Government leadership**

Establish the political will of the federal and provincial governments. Put an end to duplication and reap substantial cost savings that can be re-invested to fund and enhance the program.

**Cornerstone 4: Fund and implement the plan in phases**

Establish and finance priorities.

Work is clearly needed on the public/private funding mix. We also see the need for implementation to take place in phases, with the following suggested priorities: citizens who have no coverage; those

in seasonal employment; people between jobs; the less well off self-employed; children; pregnant women; people receiving homecare.

Developing an estimate of likely costs is very difficult and further research is needed in this area. A great opportunity exists to learn from the Quebec experience and while governments and the private sector need to examine approaches to finance, the federal government has to commit to provide an appropriate share of funding on an ongoing basis.

Before taking a look into the future, I would like to shift focus from macro level policy issues to where I believe the real issues around drug therapy are going to be solved. That is by expanding the role of the pharmacist at the community level through active collaboration between pharmacists, physicians and patients. The focus on primary care reform in many provinces creates perhaps the greatest opportunity for progress. We have paved the way for some of this work with an agreement in 1996 with the Canadian Medical Association on the respective roles and responsibilities of pharmacists with respect to pharmacotherapy<sup>20</sup>. First, although in pharmacy we are facing our own shortage crisis, pharmacists can relieve some of the burden on physicians and emergency rooms. This will require pharmacists to be granted some form of prescribing authority. A good recent example has been in British Columbia where appropriately trained pharmacists are prescribing emergency hormonal contraception<sup>21</sup>. This makes treatment available to women at the time they need it. Further development of the role of the pharmacist in accepting greater responsibility for initiating and modifying drug treatment has significant potential to save the system money.

Pharmacists also have a wider role to play in optimizing drug prescribing. This includes improving drug selection decisions by actively promoting the use of appropriate prescribing guidelines. The Port Perry project<sup>22</sup> confirmed this with respect to the prescribing of antibiotics. Improving patient education through the provision of patient compliance programs is another important role. In a recent study by CPhA, compliance of new patients was improved 13% by such a program<sup>23</sup>. In elderly patients receiving 5 drugs or more, a recent study in Ontario has shown how pharmacists conducting drug

regimen reviews were able to make critical recommendations to physicians. Drug-related problems were identified in 88% of patients in the intervention group. Over 69% of the recommendations were accepted by the physicians<sup>24</sup>.

We need further research to develop and evaluate these innovative practice models. We need further initiatives to promote multidisciplinary approaches to improving prescribing and drug use.

Such multidisciplinary opportunities reinforce the need for integrated health human resource planning to ensure optimal utilization of health human resources. This is particularly important as we work to resolve the current health care human resource crisis.

Most importantly, public and private drug plans must pay pharmacists for professional services that they provide in addition to the filling of a prescription.

We also need greater dialogue with consumers on their perception of needs. This is particularly important with respect to proposals for direct to consumer drug advertising of prescription drugs (DTCA). As an Association, we share many of the questions raised in an important recent article in *Pharmacoeconomics*<sup>25</sup> about the likely impact of such programs on drug expenditures and the appropriateness of prescribing. Until such questions are answered, we oppose DTCA, but recognize that consumers need access to drug therapy information to help make responsible decisions. To this end we are actively developing a consumer drug information web-site that we aim to link with initiatives such as the Canada Health Network.

Now we'll look to the future and the need for national pharmacare.

Much research has been undertaken to explain the escalation in drug costs. Several key drivers have been identified:

- an aging population, leading to increases in beneficiaries
- increased drug utilization, i.e., more people getting drugs and people getting more drugs
- adoption of expensive new drugs which represent advances in therapeutics

- increases in drug prices.

Based on research in British Columbia, increased utilization and increased consumption of new drugs appear to be the main drivers<sup>26</sup>. This analysis is important, because it shows that escalation in drug expenditures and problems relating to the quality of drug use will be with us for a long time.

Most recent projections say that by 2016, Canadian seniors will outnumber those under 14 for the first time in our country's history. It will be a different Canada to any we have ever known.

We are also riding a wave of discovery. The scientific community and industry are yielding steady advances in the creation and production of new medicines, technologies, therapies and preventions. Advances in genetics promise a major paradigm shift in the treatment of disease. These advances accumulate daily, but so do the questions for public policy makers: accessibility, maintaining high standards of care, safety, and, of course, affordability and value for money. All are key concerns and can only be answered by a national program.

Drugs will become more and more effective and will constitute an increasing portion of the therapies utilized and their share of health care costs will continue to rise. New drugs are expensive, but they will be prescribed and access will be demanded by an aging public that is increasingly aware of its options and knows how to vote. There are presently great disparities in the way these costs are covered, with an estimated six million Canadians inadequately insured. How well you are served also depends on where you live in Canada, which we know is of paramount concern to a national government committed to universality. While the gap between our health care *haves* and *have-nots* does not currently rival that of the U.S., when compared with Western Europe we have the dubious distinction of becoming competitive with our southern neighbours. We must reverse this trend.

For these reasons governments will have to put pharmacare back into their Redbooks before too long. An aging nation will demand it. I would underline that point by saying

— the sooner that work begins the better. To do this the federal government must take the lead and draft a plan in collaboration with the provinces and the private sector and lay out the steps and time schedule to begin the integration of existing plans. As we have suggested, the priority should be to provide basic coverage to people who currently have no coverage. Recent arguments that a national pharmacare plan would cost less than previous estimates and save money in the long run need critical examination<sup>27</sup>.

To close on the role of the pharmacist, we wish to emphasize that drug therapies must be applied effectively if they are to work and prevent further complications which lead to more intensive, expensive care. Therefore, building on the experience of existing projects, further research is needed to develop, implement and evaluate innovative approaches to drug therapy, making greater use of the knowledge and skills of pharmacists, particularly in new primary care delivery models.

New drug therapies, particularly those that take advantage of advances in genetics, are very sophisticated, and will require a multidisciplinary team approach to their use. We are seeing this already with the early advances and the emergence of pharmacogenomics<sup>28</sup>. As gene therapy becomes sophisticated in its interventions, some very significant ethical and moral debate will be required. Balancing societal and individual moral and ethical values will become particularly challenging. Also, the economic model to support such therapies will be revolutionary, since the therapy will become specific to an individual or a family or a gene pool. The pharmacist can and should play a critical role in the way these technologies roll-out.

To wrap up I will leave you with the following recommendations. We urge you to consider these views in your deliberations and we will be happy to follow up in any way to suit your needs.

## **Recommendations**

1. Finance studies to critically evaluate the quality of drug use. Evaluation research should focus on the value of interventions to improve the quality of drug use.

2. Integrate pharmacists into proposed models for primary health care delivery. Such models should be designed to make maximum use of the consultative services pharmacists provide to optimize drug therapy.
3. Pay pharmacists for the consultative services they provide to optimize drug therapy.
4. Provide tangible evidence of action in regard to the commitment to pharmaceutical management in the First Ministers Communiqué. This should take the form of a plan to reduce duplication of activity in administering public drug benefit plans.
5. Consult with the private sector to identify approaches to integrating public and private sector drug benefit plans.
6. Develop a national pharmacare plan, and in addition to recommendations 4 and 5, take a first step by ensuring that adequate coverage is provided to individuals currently without insurance, particularly low income families, children, people between jobs and the self employed.

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