McMaster University

McMaster HEALTH FORUM

EXPLORING MODELS FOR PHARMACIST PRESCRIBING IN ONTARIO

EVIDENCE >> INSIGHT >> ACTION

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this summary

On October 17, 2015, the McMaster Health Forum convened a citizen panel to explore models for pharmacist prescribing in Ontario. The purpose of the panel was to guide the efforts of policymakers, managers and professional leaders who make decisions about our health system. This summary highlights the views and experiences of panel participants about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implement these options.

The citizen panel did not aim for consensus. However, the summary describes areas of common ground and differences of opinions among participants and (where possible) identifies the values underlying different positions.

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Summary of the panel

Participants discussed challenges related to meeting health-system goals (i.e., improve access, connect services, support people and patients, and protect our universal health system) and the reasons for these challenges. They individually and collectively focused on six major challenges in particular: 1) access to primary-care providers is limited; 2) continuity of care is lacking; 3) monitoring of immunization coverage is lacking; 4) collaboration appears difficult between primary-care providers; 5) comprehensive information and technology infrastructure is lacking; and 6) how care is paid for raises important challenges.

Participants reflected on three options (among potentially many) for pharmacist prescribing in Ontario: setting up agreements that let your pharmacist (working alongside your family doctor) play a bigger role in supporting your use of prescription drugs (option 1); allowing pharmacists to give you prescription drugs (without you having to see your family doctor) when you have a minor ailment (option 2); and allowing some pharmacists with special training to give you a broad range of prescription drugs (without you having to see your family doctor) (option3). Five values-related themes emerged with some consistency: 1) competence (e.g., training and licensing of pharmacists); 2) trust (between patients and pharmacists, and between doctors and pharmacists); 3) value for money (i.e., health-system costs related to potential duplication of efforts and service fees); 4) empowerment (e.g., patients should be proactive, informed and in control of their own health records); and 5) privacy (of patient's health information).

When turning to potential barriers to implementing these options, participants focused on five sets of barriers to moving forward: 1) being clear about the problems we are trying to address; 2) having the capacity to prescribe and dispense drugs raises a potential conflict of interest; 3) there may be concerns about a perceived lack of training and skills of pharmacists to prescribe in the context of complex medical conditions; 4) there may be concerns about the implications of pharmacist-prescribing for health-system costs; and 5) there are concerns about the capacity of pharmacists to manage an expanded scope of practice. Participants then turned to four key factors that could facilitate efforts to bring about change: 1) framing pharmacist prescribing as a strategy to improve timely access to care; 2) promoting the benefits of expanding the role of pharmacists beyond drug dispensing; 3) a minor-ailment program is most likely to garner public support; and 4) further efforts to implement a comprehensive information infrastructure could facilitate pharmacist prescribing at provincial and national levels.

"You need someone who knows who you are and someone who is looking after you in every aspect."

Discussing the problem: What are the most important challenges in meeting health-system goals in Ontario?

Panel participants began by reviewing the findings from the pre-circulated citizen brief, which highlighted what is known about the underlying problem – challenges in meeting health-system goals (i.e., improve access, connect services, support people and patients, and protect our universal health system) and its causes. They individually and collectively focused on six major challenges in particular:

- access to primary-care providers is limited;
- continuity of care is lacking;
- monitoring of immunization coverage is lacking;
- collaboration appears difficult between primary-care providers;
- information and communication technology infrastructure is lacking; and
- how care is paid for raises important challenges.

We review each of these challenges in turn below.

Access to primary-care providers is limited

Discussions initially focused on the limited access to primary-care providers, which resulted in their inability to meet the growing needs of patients and monitor prescription drugs for a wide range of conditions (including minor ailments, chronic health conditions and conditions requiring immunizations).

Participants emphasized various factors influencing access to primary-care providers, including where people live (e.g., people living in urban areas versus rural and remote areas), and demographic shifts in the province. Regarding the latter point, some participants pointed out that the population is shrinking in some parts of the province, while more people are now gravitating towards larger cities. This situation appears particularly challenging for those remaining in rural and remote areas, given the difficulty of recruiting and retaining family doctors in these areas. Still referring to the demographic changes, some participants indicated that certain parts of the province are heavily populated with older populations and they should be looked at differently in terms of the specific challenges they may be facing. Demographic changes among the primary-care workforce were also sources of concerns, with a few participants indicating that they were experiencing stress and uncertainty since their family doctors were getting close to retirement.

Box 1: Key features of the citizen panel

The citizen panel about exploring models for pharmacist prescribing had the following 11 features:

1. it addressed a high-priority issue in Ontario;
2. it provided an opportunity to discuss different features of the problem;
3. it provided an opportunity to discuss three options for addressing the problem;
4. it provided an opportunity to discuss key implementation considerations (e.g., barriers);
5. it provided an opportunity to talk about who might do what differently;
6. it was informed by a pre-circulated, plain-language brief;
7. it involved a facilitator to assist with the discussions;
8. it brought together citizens affected by the problem or by future decisions related to the problem;
9. it aimed for fair representation among the diversity of citizens involved in or affected by the problem;
10. it aimed for open and frank discussions that will preserve the anonymity of participants; and
11. it aimed to find both common ground and differences of opinions.

Participants emphasized that finding and maintaining a family doctor was not easy. Very few family doctors accept new patients, which limits the capacity of patients to find the right family doctor who could meet all their expectations. As one participant said: "Sometimes, finding a doctor has to do with the patient looking for a doctor's gender and age group, in order to feel comfortable to tell them everything." Several participants commented on the fact that who you are (e.g., your ability to advocate for yourself and the complexity of your health conditions) can significantly influence access. In this respect, one participant described a very positive experience in a small community with the family physician and community pharmacist: "My local pharmacist knows me and my family very well. The doctor's office is across the street from my pharmacist, and they work well - hand in hand." This participant benefited from a "personal chain of information" addressing all healthcare needs. However, this participant acknowledged that "you have to invest a bit of your time and effort to advocate for yourself. If not, you just become a name and a number." In contrast to this participant's experience in a small community, another participant mentioned the struggles people face when living in one city, working in another city, and having the family doctor in yet another city: "I have a chronic condition and I would love [to be able to solve some of my problems] with the pharmacist, so that I do not need to see the doctor every time I need a prescription."

A young participant emphasized that the lack of access to primary-care providers is not only affecting older adults with multiple chronic health conditions, but it is also salient among younger generations. This participant pointed out that this issue often seems to be overlooked, and in general people too often assume that "if you're young, you must be healthy." However, this participant highlighted that many young people have conditions that require access to a diverse set of primary-care providers.

The discussion about access to primary-care providers also addressed the issue of wait time at the doctor's office. Several participants mentioned that they have experienced long wait times at a family doctors' clinic because patients with minor ailments (who did not necessarily need to be seen by a doctor) were consuming too much of the doctor's time, resulting in the other patients having to wait longer to be seen, and forcing the doctor to reduce the amount of time dedicated to each patient. Commenting on the amount of time patients spend at the doctor's office, at the diagnostic testing facility, and at the pharmacy, one participant stated that it would be ideal if healthcare was "set-up like a one-stop shop," with all these services in one building.

Continuity of care is lacking

The lack of access to primary-care providers also limits these providers' capacity to offer continuous and seamless care. As one participant mentioned, sometimes "refills are difficult to get even for something as simple as ibuprofen" without appropriate doctor instructions.

While several participants were attached to being able to see their family doctor on a regular basis to monitor their health conditions and prescription drugs, many noted that community pharmacists could play a greater role in this area. More specifically, they emphasized that pharmacists have the knowledge and skills to monitor more closely drug treatments, and especially issues related to drug-drug interactions, in order to alert patients when a prescription drug may be harmful (for example if your pharmacy record indicates that you are allergic to the substances contained in certain drugs). Participants also observed that pharmacists are in the best position to identify when your prescription is due and remind you of it, and they can suggest new drugs that perhaps the doctor is not yet aware of.

While granting prescriptive authority to pharmacists could alleviate some of the challenges patients are currently facing in terms of access and continuity of care, some participants expressed concern that granting such authority has the potential to increase fragmentation in the system. One participant voiced a concern about having too many people with the capacity to change her/his prescriptions (or having the authority to do so). This participant was more comfortable with having the family doctor being the only one with prescriptive authority: "I would prefer that my doctor be the only one writing prescriptions and making any changes to the prescription, and that the pharmacists dispense and inform me of medication interactions." A second participant presented a different perspective, indicating that granting prescriptive authority to pharmacists could actually bridge current fragmentation in the system. This participant pointed out that people who have multiple chronic health conditions already depend a lot on their pharmacist to "oversee the whole process" and to "set things straight when there are too many opinions about which drugs to take."

Monitoring of immunization coverage is lacking

Participants generally agreed that there was a lack of monitoring of immunization coverage at the individual level, particularly for tracking immunization schedules and boosters for adult patients. Yet, participants expressed divergent views regarding which primary-care provider is best positioned to play a role to increase immunization rates. One participant argued, and a few others agreed, that family doctors are the best healthcare professionals to manage immunizations, since they use clinical practice guidelines to keep on track for immunization schedules and boosters. In support of this side of the argument, one participant expressed concerns about the business-oriented nature of pharmacies and the potential implications for the management of vaccinations.

However, other participants argued that pharmacists could play a more significant role in managing immunizations, such as providing vaccine shots and maintaining a central immunization record, which would help alleviate the workload for doctors and allow them to spend more time with patients for more important things. Some participants added that they could see the pharmacy system becoming the support system for the mandatory immunization schedule (as, they suggested, the school system once did).

Several other issues related to immunizations were mentioned. One participant pointed out that there is inconsistency in public

Box 2: Profile of panel participants

The citizen panel aimed for fair representation among the diversity of citizens likely to be affected by the problem. We provide below a brief profile of panel participants:

- **How many participants?**
  13
- **Where were they from?**
  Region covered by the Hamilton Niagara Haldimand Brant Local Health Integration Network
- **How old were they?**
  18-24 (1), 25-44 (1), 45-60 (6), 61-70 (5)
- **Were they men, or women?**
  Men (6) and women (7)
- **What was the educational level of participants?**
  Four participants completed high school, two completed community college, four completed a bachelor's degree, and three completed post-graduate training
- **What was the work status of participants?**
  Seven participants were working full time, one was working part time, and five were retired
- **What was the income level of participants?**
  Six participants earned between $20,000 and $40,000, three between $40,000 and $60,000, three over $60,000, and one preferred not to disclose their income
- **How were they recruited?**
  Selected based on explicit criteria from the AskingCanadians™ panel

information about some specific vaccinations, as well as in how these vaccinations are carried out. This participant gave the example of the human papillomavirus (HPV) vaccination that is offered in some schools and not in others, and the limited amount of proper public education about this vaccination, all of which can leave some patients uncovered. Another participant pointed out that some vaccines, such as for shingles, are not covered by the Ontario Health Insurance Plan (OHIP). A few participants commented on the added difficulties related to the coordination of the advance ordering required for some vaccines, and the scheduling of a visit to the doctor's office within 24 hours of the vaccine's arrival at the clinic. They suggested that pharmacies could be another type of 'one-stop shop': pharmacists could order the vaccine, keep it in the pharmacy, and then vaccinate the patients in the pharmacy without them having to visit their doctor.

Collaboration appears difficult between primary-care providers

All participants agreed that communication among primary-care providers is critically important in order for the patient to receive optimal care and achieve optimal health outcomes. Discussions about collaboration focused on three sets of challenges: 1) limited communication between doctors and pharmacists, 2) concern about staff turnover in community pharmacies, and c) the need to empower patients to facilitate and nurture collaboration and communication between primary-care providers.

Many participants acknowledged that, in general, doctors and pharmacists communicate with one another, but such communication appears too limited to achieve true interprofessional collaboration. Some participants mentioned that collaboration between doctors and pharmacists could be improved through the electronic transfer of information (not by fax, but in electronic form that gets captured in a patient's record both at the pharmacy and at a doctor's office). In addition, database-triggered automatic reminders to doctors, telling them when a patient's prescription is running out, would help by prompting the doctor to send a prescription to the pharmacy, so that the patient could pick it up. One participant indicated that a greater sense of shared accountability for patient outcomes could lead to greater interprofessional collaboration. Another participant said there is a perception that there is no shared accountability: "The pharmacist is not responsible for the patient outcomes; the doctor is still the one that is responsible."

In addition, some participants experienced regular staff turnover in large pharmacy chains, which could make it difficult for a doctor to establish a relationship (and thus enhance communication and collaboration) with individual pharmacists. As one participant observed: "Doctors stay in their clinic for long periods of time and get to know you well, but there sometimes is a high turnover of pharmacists." The perceived staff turnover in community pharmacies also raised concern about the 'transfer' of knowledge within each pharmacy to newer pharmacists. One participant wondered whether, if pharmacists were to start prescribing, they "should be allowed to prescribe if they do not have a strong relationship with the patients and do not know them well." A second participant argued that if your history and your information remain in the system, this shouldn't create a problem as long as pharmacists are well trained and have access to that information: "That's how they know you."

A few participants emphasized the need to empower patients to facilitate and nurture interprofessional communication and collaboration, which could ultimately lead patients to play a greater role in ensuring continuous and seamless care. As one participant said: "Sometimes people become too reliant on doctors. … Patients need to be proactive and more responsible for their own prescription refills."

Comprehensive information and technology infrastructure is lacking

Several participants commented on the challenges that currently exist because patient information is fragmented and maintained in multiple places (e.g., patient information can be maintained at one or more doctor's offices, as well as one or more pharmacies). Participants also expressed some irritation because they don't fully own their own health information. Some participants shared their experience when asking for their records to be transferred from one pharmacy to another, and being asked to pay a fee to complete the transfer.

Some participants emphasized the importance of addressing the fragmentation of information and called for the use of electronic-information sharing via a centralized system, possibly having everything linked through your health card. One participant stated that "having electronic info readily available to the right people at the right time could solve a whole set of issues, and it isn't that difficult to set-up the parameters." Many participants claimed that patients should have access to their own information and envisioned a system

where this information would be available on their personal computers or mobile devices. "I would love to be able to see my own record." In response to the need to have access to their individual record, one participant commented that older adults might be left behind given their limited level of digital literacy and use of electronic devices.

Several participants argued that personal health information should be shared Canada-wide and throughout all chains and all pharmacies, not just provincially. Many participants agreed that it would be beneficial to have a nation-wide electronic system, one "central huge database that every doctor and pharmacist has access to."

The discussion about making records available in a centralized database then turned to privacy and confidentiality considerations. Some participants raised questions related to computer network security and hacking issues, and others shared their concern about the information being "too open and available to anyone to see," even to people who should not be authorized to see it (for example, stories in the news about border crossing officers having access to patient information). One participant was concerned about patients losing their jobs if unauthorized people got access to their complete records. Two other participants raised the general issue of privacy, and one participant cautioned about giving pharmacists personal health information because of how pharmacists are associated with businesses. However, one participant pointed out, and several agreed, that a well-designed system with different levels of security and authorization would address most of these concerns. This participant emphasized that there is a lot of information already "shared out there through your healthcare – how many times you go to the doctor, which doctor, etc." This participant added: "The only thing that is missing is the medication part. … The information is already there today. It's just that it's on different systems. You just need to pull it out of these systems and centralize it."

With respect to recent efforts to create technology platforms for electronic health records, participants commented about the limited returns on investments to date. One of these participants felt that significant investments have gone to waste, and little progress has been made in e-health in the province.

How care is paid for raises challenges

Several participants mentioned challenges related to how care is paid for, with four distinct challenges being identified: 1) the limit in the amount of time (in some practices only 10 minutes) that is allocated to each patient consultation with family doctors; 2) the limit in the number of medical concerns (in many practices only one) that can be raised in a single consultation with family doctors (in other words, if you have more than one concern, you have to book more than one appointment); 3) the increasing 'business orientation' in healthcare (e.g., the need to sign contractual agreements to join a Family Health Team, family doctors being aware that if their patients are seen by other primary-care providers they would lose income, and community pharmacies being owned by big chains); and 4) the rules established by insurance companies that can affect continuity of care.

A few participants shared their concern about the limited amount of time that some family doctors dedicate to each patient, and commented that they believe this is because doctors want to increase their income (and in doing so they are shifting the way in which they provide care, for example "running from one patient to another"). Several participants commented that the requirement that exists in some practices for patients to book multiple appointments in order to address multiple concerns separately (one appointment per concern) may also be caused by how payments to physicians are made. One participant emphasized how significant he felt these first two challenges were, commenting that "[this is] a systemic issue, so pharmacist prescribing would be such a small issue compared to the big issue that doctors do not [have time to] look at the patient" sufficiently.

One participant mentioned, and several others agreed, that "medical care has become a real business." Participants talked about the business orientation that they see in how family physicians operate, as well as in how pharmacies operate. One participant gave the example of patients having to sign a contract once they find a family doctor who will accept them as new patients. Another participant, who must obtain care in a specific type of primary-care model that operates only in some settings in Ontario, reported having been warned that if patients who are rostered with a physician's practice go to a walk-in clinic, the physicians may be faced with financial penalties levied by the government. Furthermore, several participants commented, with respect to how pharmacies operate, that they are real businesses, and therefore looking for revenue. One participant said that "pharma chains care about their bottom line, not your bottom line." Many participants worried that, given the business-oriented nature of pharmacies, some pharmacists may be more inclined to

prescribe drugs (as opposed to recommending a non-pharmaceutical treatment for minor ailments, for example) and this situation may potentially lead to over-prescribing. In addition, one participant mentioned that many pharmacists are business owners and as such they might have a direct self-interest in prescribing drugs that may be more expensive.

Lastly, some participants pointed out that insurance companies have established rules that can affect continuity of care. For instance, insurance plans often do not allow you to get larger supplies of medications (e.g., patients requiring supplies for two-to-three months, but the insurance companies would only allow a 30-day supply).

"I want to be able to pick someone who is caring, knowledgeable, and does not make mistakes."

Discussing the options:

How can we address the problem?

After discussing the challenges that together constitute the problem, participants were invited to reflect on three options (among potentially many) for pharmacist prescribing in Ontario:

1) setting up agreements that let your pharmacist (working alongside your family doctor) play a bigger role in supporting your use of prescription drugs;
2) allowing pharmacists to give you prescription drugs (without you having to see your family doctor) when you have a minor ailment; and
3) allowing some pharmacists with special training to give you a broad range of prescription drugs (without you having to see your family doctor).

Several values-related themes emerged during the discussion about these options, with five emerging with some consistency: 1) competence (e.g., training and licensing of pharmacists); 2) trust (between patients and pharmacists, and between doctors and pharmacists); 3) value for money (i.e., health-system costs related to potential duplication of efforts and service fees); 4) empowerment (e.g., patients should be proactive, informed and in control of their own health records); and 5) privacy (of patients' health information). We review the themes that emerged for each option in more detail below.

Option 1 – Setting up agreements that let your pharmacist (working alongside your family doctor) play a bigger role in supporting your use of prescription drugs

The first option aims to facilitate the adoption of collaborative practice agreements that let a pharmacist (working alongside a family doctor) play a bigger role in supporting the use of prescription drugs. Under such agreements, a family doctor could diagnose and make initial treatment decisions with a patient, but delegate prescriptive authority to a pharmacist who would then have the flexibility to select, initiate, monitor, adapt and decide whether to continue or deprescribe a drug (as appropriate). All primary-care providers taking part in collaborative practice agreements would share the risk and responsibility for the patient outcomes.

Five values-related themes emerged during the discussion about option 1:

- attuned to the diversity of needs of patients (e.g., need for clear guidelines based on patients' age, types of medical conditions, and number of medical conditions);
- trust (between patients and pharmacists, and between doctors and pharmacists);
- value for money (i.e., health-system costs related to potential duplication of efforts and service fees);
- choice (e.g., patient's ability to choose their pharmacist who will be part of a collaborative agreement); and
- empowerment (e.g., patients should be proactive, informed and in control of their own health records, and patients should take initiative and advocate for themselves).

Participants had mixed views about option 1. A small number of participants mentioned that they saw some potential benefits in setting collaborative prescribing agreements: 1) it may improve access to care since access to pharmacists is usually more convenient (e.g., pharmacists usually do not require an appointment and are available during weekends) and they seem to be able to provide more time than family doctors for discussing drug treatment options with patients; 2) pharmacists may have the knowledge and skills to monitor the patient's drug treatment more closely; and 3) pharmacists may be more aware than family doctors of newer and more effective prescription drugs. One participant saw that this option would be particularly valuable (and most likely easier to implement) in cases where pharmacists are full members of Family Health Teams or other collaborative practice models.

However, most participants raised a number of concerns and pointed to a number of potential flaws, especially if these collaborative prescribing agreements are made with community pharmacists (as opposed to pharmacists who are part of a Family Health Team). For instance, this option would entail special agreements between doctors and pharmacists that would require: 1) additional resources on both sides for negotiating and confirming the agreement, for which doctors and pharmacists may want to claim a fee; and 2) identifying the specific pharmacist entering into the agreement, which may create confusion if the patient expects that anyone in the pharmacy could be prescribing for them. Regarding the second point, several participants mentioned the need to clarify whether the agreement would be between a family doctor and an individual pharmacist, or whether the agreement would extend to the pharmacy team as a whole[1]. As noted earlier, some were concerned about the turnover of pharmacists, especially those working for larger chains. Thus, collaborative prescribing agreements made between individual family doctors and pharmacists may not be sustainable.

Participants noted that this option would also entail setting up guidelines and rules

Box 3: Key messages about option 1

- Participants had mixed views about this option.
- Five values-related themes emerged during the discussion about option 1:
  - attuned to the diversity of needs of patients (e.g., need for clear guidelines based on patients' age, types of medical conditions, and number of medical conditions);
  - trust (between patients and pharmacists, and between doctors and pharmacists);
  - value for money (i.e., benefits in relation to health-system costs related to potential duplication of efforts and service fees);
  - choice (e.g., patient's ability to choose the pharmacist who will be part of a collaborative agreement);
  - empowerment (e.g., patients should be proactive, informed and in control of their own health records, and patients should take initiative and advocate for themselves).

[1] Editorial note: the authors clarified after the panel that the medical directive would need to be established with each pharmacist.

related to the diversity of patient needs - such as the types of ailments and types of drugs for which delegated authority would be given to pharmacists - and would have to be implemented across the board.

Some participants raised question regarding the 'value for money' of option 1. They expressed concern that this option may create duplication of efforts and increased costs, and may shift the workload from the family doctor's office to the pharmacy, putting the burden on the pharmacist for dealing with a large volume of patients.

In addition, participants emphasized the fundamental need for trust among all those taking part in a collaborating prescribing agreement (including patients). Trust will have to underpin both the development of agreements and their implementation in practice. However, given the current lack of interprofessional communication and collaboration, some participants suggested that this would be unlikely.

A few participants raised the issue of compensating doctors for the time they would spend on establishing these agreements, and one participant wondered whether some doctors would be reluctant to see this option implemented since it would mean a potential loss of income for their clinic (if the patient would instead see a pharmacist) and more work for them (to capture in their patients' records all the updates that they would receive from the pharmacists). A couple of participants also wondered whether doctors may only want to deal with a small number of pharmacists (and therefore have a manageable number of agreements in place) and cautioned that some doctors may even be offended if the patients would dictate which pharmacist to choose.

Two participants wondered whether there should be a difference between the pharmacist who holds the agreement with the doctor and therefore has the authority to prescribe, and the dispensing pharmacist. Several participants commented that in their view this tiered arrangement would actually take up resources, as two pharmacists would have to be involved. One participant pointed out that the dispensing is done in most cases by pharmacy technicians, however, a licensed pharmacist needs to be physically present in the pharmacy and bears the responsibility for verifying the accuracy of the prescription and the dispensing of the drugs.

There were conflicting opinions among participants with respect to efficiencies and value for money. On one hand, some participants argued that option 1 would likely increase healthcare costs by duplicating effort ("we're paying twice for this model; we're making our

healthcare more expensive"), and that, for patients with multiple or complex medical conditions, the pharmacist would be required to know the patient as well as the doctor. On the other hand, a few participants argued that this model could actually mean less cost. "There are savings by not having as many patients seen by doctors."

Several participants commented on the increased number of patient consultations that the pharmacists would be faced with, and one participant suggested that "there will have to be a triage system in the pharmacy."

During the discussion related to option 1, the concept of a pharmacist acting as a 'consultant to the doctor' emerged, but participants acknowledged that this 'consultation' model does not refer to dispensing of drugs, but rather to the pharmacist being considered part of the team, somewhat similar to the Family Health Team model - an 'in-house resource' even if the pharmacist is not physically at the same location as the doctor. Many participants argued that if a system was to be set up where pharmacists would be part of the team (as staff), then the model would have to be established everywhere consistently.

Throughout the discussion related to option 1, the vast majority of participants emphasized repeatedly the importance of allowing the patients to choose their pharmacist. One participant said: "I want to be able to pick someone who is caring, knowledgeable, does not make mistakes." Another said: "I do not want my doctor to pick my pharmacist for me."

In addition, several participants shared their views and experiences with respect to taking control of their condition and their needs, and educating themselves. They emphasized the value of patient empowerment. "The patient has to be open and honest about what they expect. The patient is the receiver of the care; he's the end user."

Option 2 – Allowing pharmacists to give you prescription drugs (without you having to see your family doctor) when you have a minor ailment

The second option aims to allow pharmacists to become a first point of contact for patients requesting advice about treating minor, self-limiting, and self-diagnosed conditions. The pharmacists could also prescribe drugs in situations where no diagnosis is required (e.g., a

vaccine, oral contraceptives, and preventive therapy for travel, such as an anti-malarial for prophylaxis or an antibiotic for traveller's diarrhea). If the self-diagnosis is reasonable based on clinical guidelines, the pharmacist would have the authorization to prescribe. If the pharmacist is unable to confirm the patient's self-diagnosis and/or the patient's symptoms are severe, the pharmacist would refer the patient to a physician or another appropriate primary-care provider.

Six values-related themes emerged during the discussion about option 2:

- competence (pharmacist training should be done across the system, so that all pharmacists can prescribe for minor ailments);
- safety (concern about self-abuse in patients who may be getting the same drug from multiple pharmacies, and patients self-diagnosing);
- neutrality (avoiding potential conflict of interest when prescribing and dispensing drugs);
- stewardship (the responsible planning and management of resources to ensure that pharmacists have enough capacity to tackle an increased workload);
- empowerment (of patients - same theme as during the discussion about option 1 - and of pharmacists); and
- privacy (ensuring the privacy and confidentiality of health information).

Participants generally supported option 2, and mentioned that they saw numerous benefits to this option, as long as: a) the conditions for which pharmacists would prescribe drugs without participants needing to see their family doctor were minor, self-limiting, self-diagnosed conditions, or were situations for which diagnosis is not required (e.g. vaccines, oral contraceptives, etc.); b) the pharmacists would have adequate training to support the self-diagnosis made by a patient; and c) the option would be implemented across the system, so that all pharmacists across the province would be able to prescribe for minor ailments. As one participant emphasized: "We self-diagnose all the time."

Many participants commented that they would expect all pharmacists "across the system," to have the same level of competence in prescribing for minor ailments. A number of participants commented that in addition to the pharmacists' required level of competence in prescribing drugs for minor ailments, with appropriate training they would also be well positioned to confirm a patient's self-diagnosis, or to explain what other causes may produce the same symptoms, and that the pharmacists would also be well positioned to advise when the patients should see their doctor. In addition, they commented that the

pharmacists would have to be responsible for identifying and pointing out to patients when they think the patients are abusing the system, or they are "worrying too much and coming too often with the same minor thing." In this respect, the value for money theme re-emerged, with several participants reiterating their earlier concern related to an increase in the workload for pharmacists.

Three sets of considerations emerged with respect to option 2: 1) safety considerations, with respect to both patients self-diagnosing and a small number of patients potentially doing harm to themselves by getting the same drug from multiple pharmacies; 2) the need for stewardship of the system's scarce resources to ensure that pharmacists have enough capacity to tackle an increased workload (with large numbers of self-diagnosing patients); and 3) the need for neutrality when prescribing and dispensing drugs, given pharmacists' potential conflict of interest due to their potential role in both prescribing and dispensing drugs (although for this last point several participants commented that they do not see a significant issue since prescriptions would be for minor ailments).

When prompted to consider how this option may compare to allowing more drugs to become available over-the-counter (OTC) without a prescription (a point that had been raised by a key informant in an interview with the authors of the citizen brief), participants raised a number of issues related specifically to OTC drugs: 1) patient

Box 4: Key messages about option 2

- Participants generally supported option 2
- Six values-related themes emerged during the discussion about option 2:
    - competence (pharmacist training should be done across the system, so that all pharmacists can prescribe for minor ailments);
    - safety (concern about self-diagnosis as well as about self-abuse in patients who may be getting the same drug from multiple pharmacies);
    - stewardship (the responsible planning and management of resources to ensure that pharmacists have enough capacity to tackle an increased workload);
    - neutrality (avoiding potential conflict of interest when prescribing and dispensing drugs);
    - empowerment (of patients – same theme as during the discussion about option 1 – and of pharmacists); and
    - privacy (ensuring the privacy and confidentiality of health information).

safety with respect to potential for self-harm and to inappropriate dosage, or side effects and adverse effects (especially for people who are taking multiple medications, or for older patients); 2) public health safety (for example antibiotic resistance); and 3) cost (incurred by the patient for OTC drugs versus the cost potentially being incurred by insurance plans for prescription drugs).

In addition, several participants re-stated their views and experiences with respect to taking control of their own condition and needs, and educating themselves. Greater patient empowerment was seen as critical in order to successfully implement a minor ailment program.

Lastly, the issue of privacy emerged again. While having a centralized information and communication infrastructure would be essential to support the implementation of a minor ailments program, several participants hinted that they would like to have the capacity to request that some minor conditions to be expunged from their records (e.g., a minor condition that can be embarrassing or sensitive, but that the patient prefers to keep private).

Option 3 – Allowing some pharmacists with special training to give you a broad range of prescription drugs (without you having to see your family doctor)

The third option aims to allow individual pharmacists to apply to obtain additional prescribing authorization. Under such a model, the Ontario College of Pharmacists would issue licences to individual pharmacists meeting specific requirements to grant additional prescribing authorization (APA). A pharmacist with an APA licence would have the authority to independently prescribe certain drugs and vaccines.

Six values-related themes emerged during the discussion about option 3:

- competence (training and licensing of pharmacists)
- accountability (regarding training and licensing);
- timely access (the number of pharmacists who hold APA licences, and where they are located);
- collaboration (between pharmacists, patients, doctors, and other primary-care providers); and
- privacy (of health information) and trust (between patients and pharmacists regarding the use of patient data).

Box 5: Key messages about option 3

- With one exception, participants were generally not supportive of option 3.
- Six values-related themes emerged during discussions about this option:
  - competence (training and licensing of pharmacists);
  - accountability (regarding training and licensing);
  - timely access (number pharmacists who hold APA licences, and where they are located);
  - collaboration (among pharmacists, patients, doctors, and other primary-care providers); and
  - privacy (of health information) and trust (between patients and pharmacists regarding the use of patient data).

Only a few participants were supportive of option 3. One participant mentioned that this option could work as long as pharmacists have adequate training and credentials, and have a significantly expanded scope of practice (e.g., being responsible for monitoring and follow-up, as a doctor would). A second participant was initially 'on the fence,' considering that "if the doctors can be trained, the pharmacists can be trained as well." However later in the discussion the same participant concluded that there are too many concerns related to this option to support it.

Overall, participants questioned the desirability and feasibility of this option. For instance, some felt that this option would be "giving pharmacists too much privilege," while others wondered whether it would position some pharmacists as a new class of health professionals, somewhere in-between doctors and what we now think of as pharmacists.

The competence and accountability themes that emerged during the discussion covered a number of considerations. First, several participants mentioned that they would like pharmacists to be accountable for the monitoring and follow-up of patients, as long as these patients do not have complex conditions. Second, participants expressed their personal view

that pharmacists do not have the level of competence required for monitoring certain types of chronic and complex conditions. Third, the discussion touched on whether pharmacists should be making diagnoses, and some participants argued strongly that pharmacists would not be well positioned to do so. Several participants suggested that licensing criteria and a training program (addressing both monitoring and diagnosis) would need to be developed before option 3 could be entertained. Participants noted that option 3, as presented, did not include a requirement for previous diagnostic experience (and, as pointed out by a few participants, it would not be possible for pharmacists to acquire this experience anyway, in the absence of an APA).

Many participants were skeptical about whether option 3 would be able to help improve timely access to care. They pointed out that only a potentially small number of pharmacists would likely have APA, and patients would be uncertain about how to identify which pharmacists hold the APA licence, where they are located, and whether the distance would make the travel worthwhile.

Participants also commented on the complexity of collaboration that would be required among patients, pharmacists, physicians, and other healthcare professionals and service providers, in order to make this option work, and shared their concern that this may actually increase the workload for all stakeholders involved. In addition, several participants also argued that drugs are not always the 'go to' solution, and mentioned that other treatment choices may be available instead of or in conjunction with drugs (for example physiotherapy). They pointed out that while collaboration in this case would include referrals for these other treatment choices, pharmacists would need to have the ability to provide these referrals.

Participants also expressed concern with respect to the privacy of health information and the fact that pharmacists would have access to patients' entire health record. They mentioned that it may be difficult to build the level of trust required to alleviate the privacy and confidentiality concerns that patients would have.

One participant commented on another dimension of the trust value, namely the patient's confidence that the most appropriate treatment is being offered to patients. He was under the impression that the health system had a tendency towards attempting to keep a medical condition managed using drugs, instead of potentially more effective but more expensive options (for example surgery).

"[Having] electronic information readily available to the right people at the right time could solve a whole set of issues."

Discussing the implementation considerations:

What are the potential barriers and facilitators to implementing these options?

After discussing the three options (among potentially many) for pharmacist prescribing in Ontario, participants examined potential barriers and facilitators for moving forward. Participants focused on five sets of barriers to moving forward: 1) being clear about the problems we are trying to address and whether pharmacist-prescribing is a solution; 2) having the capacity to prescribe and dispense drugs raises a potential conflict of interest, which is a concern that may be exacerbated by the business orientation of pharmacies; 3) while pharmacists appear to be competent to prescribe for minor ailments, there may be concerns about a perceived lack of training and skills to prescribe in the context of more complex medical conditions; 4) there may be concerns about the implications of pharmacist-prescribing for health-system costs; and 5) there are concerns about the capacity of pharmacists to manage an expanded scope of practice (i.e., pharmacist prescribing may significantly increase the burden on already busy pharmacists). Regarding the last point, several participants stated their concerns about the adequacy of resources for pharmacists

to play a greater role. As one participant said: "If we're all now going to go to the pharmacists for shots and other things, would that turn into a waiting game again?" A second participant wondered: "Are we putting the workload from one healthcare professional onto the shoulders of another?"

Participants then turned to four key factors that could facilitate efforts to implement pharmacist-prescribing models in Ontario: 1) framing pharmacist prescribing as a strategy to improve timely access to care; 2) promoting the benefits of expanding the role of pharmacists beyond drug dispensing ("[they can play a] very healthy role in the care of the patient"); 3) a minor-ailment program is most likely to garner public support (particularly given recent efforts to train pharmacists to prescribe for minor ailments and the development of guidelines to support this); and 4) further efforts to implement a comprehensive information infrastructure (i.e., electronic health records, drug-information system, and communication system between pharmacists and primary-care providers) could facilitate pharmacist prescribing at the provincial and national levels (while preserving the privacy and confidentiality of patient data). In addition, some participants debated the value of attaching the issue of pharmacist prescribing to current debates regarding a national drug plan. One participant emphasized the leadership role that could be played by the province in this area: "As one of the leading provinces with a large population, Ontario should be leading the process."

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