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Expanding Pharmacist Services in Québec: A Health Reform Analysis of Bill 41 and its Implications for Equity in Financing Care

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Abstract

On 8 December 2011, Québec's Minister of Health and Social Services amended the province's *Pharmacy Act* by introducing Bill 41 to expand pharmacists' role in patient care. Québec is the only Canadian province with a legal mandate for prescription drug insurance coverage for all residents, with public coverage offered only to those who do not have access to private health insurance through their employer. Bill 41 aims to increase access to health care and reduce physician wait times by extending the scope of pharmacist services to mirror that of physicians (e.g., modify the form of the medication and its dosage). The reform is currently pending due to disputes between the Ministry of Health and Social Services and the Quebec Association of Pharmacy Owners over remuneration for pharmacists. Should Bill 41 come into force, it is unclear whether the expansion of pharmacists' roles, which in principle would duplicate physician services, should be considered part of the public basket of medically necessary care. Current negotiations suggest that only those with public coverage will also be covered for expanded services thereby placing equity of finance for those with private insurance in question.

Le 8 Décembre 2011, le ministre de la Santé et des Services sociaux du Québec a modifié la Loi sur la pharmacie en introduisant le projet de loi 41 à élargir le rôle des pharmaciens dans les soins aux patients. Le Québec est la seule province canadienne avec un mandat légal pour la couverture d'assurance-médicaments pour tous les résidents avec la couverture publique offerte uniquement à ceux qui n'ont pas accès à l'assurance-maladie privée par leur employeur. Le projet de loi 41 vise à accroître l'accès aux soins de santé et réduire les temps d'attente chez le médecin en élargissant le champ des services pharmaceutiques pour refléter ceux des médecins (ex: modifier la forme du médicament et son dosage). La réforme est actuellement en cours en raison de différends entre le ministère de la Santé et des Services sociaux et l'Association québécoise des pharmaciens propriétaires par rapport à la rémunération des pharmaciens. Si le projet de loi 41 entre en vigueur, il est difficile de prévoir si l'expansion de service des pharmaciens devrait être considérée comme faisant partie du panier de services publics de soins médicalement nécessaires. Les négociations en cours suggèrent que seulement ceux avec la couverture publique seront également couverts pour les nouveaux services plaçant ainsi l'équité du financement pour ceux qui ont une assurance privée en question.

Key Messages

- The implementation of Bill 41 to expand pharmacist services in Québec is delayed due to disputes between the Ministry of Health and the Québec Association of Pharmacy Owners regarding pharmacist remuneration.
- The current state of negotiations suggest that only those who are publicly insured for prescription drugs will also be covered for receiving new services offered by pharmacists.
- Given the mandate for universal drug coverage in Québec, selective coverage would result in delisting a service based on insurance status which potential implications for equity of finance.

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- *La mise en œuvre du projet de loi 41 pour étendre les services de pharmaciens au Québec est en suspens en raison de différends entre le ministère de la Santé et l'Association québécoise des pharmaciens propriétaires au sujet de la rémunération des pharmaciens.*
 - *L'état actuel des négociations suggère que seuls ceux qui sont publiquement assurés pour les médicaments sur ordonnance seront également couverts pour recevoir les nouveaux services offerts par les pharmaciens.*
 - *Compte tenu du mandat de la couverture universelle des médicaments au Québec, la couverture sélective entraînerait le retrait de services fondée sur le statut d'assurance avec des implications potentielles pour l'équité du financement.*

1 INTRODUCTION

On 15 November 2011, Québec’s Minister of Health and Social Services introduced Bill 41 to amend the *Pharmacy Act* and expand pharmacists’ role in patient care. The reform aimed to increase access to health care by addressing physician wait times with proposed amendments passed on 8 December 2011. Bill 41 detailed five major changes that extended the scope of pharmacist services by allowing them to: 1) within conditions on the renewal period, renew prescriptions to avoid interruptions in a patient’s treatment regime; 2) modify prescriptions according to the form of the medication, its dosage, and by substituting the drug for another in the same therapeutic subclass; 3) administer medication with the aim to show patients how to take it properly; 4) prescribe medication to treat conditions that do not require a diagnosis (e.g., urinary tract infections, cold sores, seasonal allergies); and 5) prescribe and interpret lab test results if the pharmacist practices in a health or social services institution (Québec National Assembly 2011). These proposed changes would mostly affect community pharmacists who represent 71% of pharmacists in Québec (Ordre des pharmaciens du Québec 2014).

Despite the legislative changes produced by Bill 41, reform implementation is pending due to disputes between the Ministry of Health and the Québec Association of Pharmacy Owners (AQPP) regarding pharmacist remuneration. These negotiations are complicated by the duplicative private health insurance arrangement that exists in Québec. Indeed, Québec is the only Canadian province with a legal mandate for prescription drug insurance coverage for all its residents (Quesnel-Vallée 2013). However, given the exclusion of prescription drug coverage from medically necessary services listed under the *Canada Health Act*, this mandate has not been implemented through a universal pharmacare program in Québec. Instead, public coverage is only available to individuals who do not otherwise have access to private insurance coverage, and as such, 60% of Québécois are not eligible for public coverage yet are mandated to obtain private health insurance through their employer. Thus, it is unclear whether this expansion of pharmacists’ roles, which in principle mirrors physician services, should be considered part of the public basket of medically necessary care. If they come to be viewed as such, then these services should be publicly insured for the entire population. However, current negotiations suggest that only those publicly covered for prescription drugs will also be covered for expanded pharmacist services. This has led to uncertainty for privately insured individuals regarding the reimbursement of these services when delivered by pharmacists, which places equity of finance in question. This issue will be examined using the example of Bill 41 in Québec and the legislative changes made to the Health Insurance Act (R.S.Q., c.A-29).

2 HISTORY AND CONTEXT

Figure 1 summarizes the similarities and differences across the provinces with regard to the policies that expand pharmacist services (Canadian Pharmacists Association 2014). A

more comprehensive summary can be found in the Canadian Pharmacists Association's report for 2013 (Canadian Pharmacists Association 2013). The figure highlights provincial variation and the extent to which pharmacists are involved in patient care. Québec trails behind all other provinces due to the postponement of Bill 41, which has resulted in a series of pending changes.

Figure 1: Summary of expanded pharmacists' roles across provincial jurisdictions

Service	Province									
	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Offer emergency refills	✓	✓	✓	✓	✓	RP	✓	✓	✗	✓
Renew and extend prescriptions	✓	✓	✓	✓	✓	RP	✓	✓	✓	✓
Alter dosages and formulations	✓	✓	✓	✓	✓	RP	✓	✓	✓	✓
Initiate therapeutic substitutions	✓	✓	✓	✗	✗	RP	✓	✓	✓	✓
Prescribe for minor conditions	✗	✓	✓	✓	✗	RP	RP	✓	✗	✗
Initiate drug therapy	✗	✓	✓	✓	✓	RP	✓	✓	✗	✗
Order and interpret lab results	✗	✓	✗	✓	RP	RP	✓	✓	✗	✗
Administer drugs by injection	✓	✓	✗	✓	✓	RP	✓	✓	RP	RP

BC = British Columbia; AB = Alberta; SK = Saskatchewan; MB = Manitoba; ON = Ontario; QC = Quebec; NB = New Brunswick; NS = Nova Scotia; PEI = Prince Edward Island; NL = Newfoundland

SOURCE: Adapted from the Canadian Pharmacists Association (Canadian Pharmacists Association 2014)

Within Canada, Québec continues to fare the worst in comparison to other provinces with regard to the proportion of the population without a regular primary care physician (Katz, Glazier & Vijayaraghavan 2009). Over 20% of Québec's population is without a regular physician with Montreal having the highest percentage of individuals reporting no usual provider of care (Institut de la statistique du Québec 2013). Québecers also report the longest delays before obtaining an appointment with a family doctor in comparison to other provinces (Lévesque & Bénégeri 2009).

The importance of community pharmacists in patient care was highlighted in a World Health Organization report citing efficient drug management as key to a well-organized health system (World Health Organization 1994). Among other factors, "efficient drug management" referred to collaboration between pharmacists and other health professionals, namely physicians (World Health Organization 1994). Patient-centered pharmacy has become integral to Canadian pharmaceutical science curriculums, yet the extent to which pharmacists can apply theory to practice varies across the provinces.

Bill 41 was introduced on the premise that pharmacists represent a natural gateway to accessing primary care. The Order of Pharmacists maintains that the reforms would improve access to primary care, particularly for those without a family doctor, and by extension address problems of delaying treatment due to limited access to physicians (Ordre des pharmaciens du Québec 2014; Rémillard 2014). Previous policies introduced to improve access to primary care in Québec include team-based models of service delivery (Levesque *et*

al. 2012), yet problems with accessing physician services remain (Health Council of Canada 2010). It is unclear whether this reform would definitively achieve this aim. Furthermore, while arguments are made for the potential to reduce health care costs by integrating pharmacists in primary care practices, the supportive evidence is tenuous (Canadian Health Services Research Foundation 2012). Nonetheless, the Ministry of Health and the Order of Pharmacists are unanimous in claiming that expanding the role of pharmacists would allow for greater access to care (Ordre des pharmaciens du Québec 2014).

3 INFLUENTIAL FACTORS: INSTITUTIONS, INTERESTS AND IDEAS

A survey of the media coverage chronicling negotiations between the two main stakeholders, Québec's Ministry of Health and the AQPP, provides insight on their shared and divergent interests. In the months leading up to the anticipated implementation date of Bill 41, news reports focused on the consensus between government and pharmacist representatives that expanding pharmacist services had the potential to improve access to primary care services by reducing wait times in clinics and emergency departments (Fidelman 2013). Critical to progress in the discussions between the Ministry of Health and the AQPP was support from Québec's College of Physicians that agreed to provide training for pharmacists who would undertake diagnostic and lab test interpretations. As of September 2013, 6,000 of 6,100 pharmacists across the province had completed their training (CBC News 2013a; Service Canada 2013). Given the substantial up-take by pharmacists, the implementation of Bill 41 would be a step forward for the Ministry of Health in addressing the thorny issue of wait times.

The reform may also raise the prestige of the pharmacist profession, by increasing their clinical responsibilities and autonomy and thus dampening the stereotype of being first and foremost business owners. Furthermore, these expanded responsibilities could decrease their relative isolation from other health professionals, and even lead to greater involvement in models of team-based care (Fidelman 2013). The AQPP expected that their increased professional responsibilities would be remunerated accordingly, and this was apparently supported by the Ministry of Health (Richer 2013), with whom they engaged in lengthy negotiations. The Fédération des médecins omnipraticiens du Québec (FMOQ, representing general practitioners) immediately countered with a campaign voicing concerns about many facets of the law, and requested that physicians also be remunerated for renewing prescriptions, an act that is not formally covered by the public system (Fédération des médecins omnipraticiens du Québec 2012). Disagreements over the government's willingness and capacity to pay for expanded pharmacist services have halted discussions between the parties and stalled the implementation of Bill 41.

3.1 Who pays? Potential implications of Bill 41 on equity of finance

The most recent actors to voice their discontent with the government's position are private insurance companies. In an open newsletter published on its website, Desjardins Insurance cited threats to universal access to health care as one of its main motivations for denouncing the proposed financing scheme (Desjardins Insurance 2013). While this statement is unclear in terms of real implications for access, raising these concerns may have been a strategy for reducing the reform's public support. Publicly funded health care has become an integral part of national identity; poll results consistently show Canadian pride in their health system's founding principles of universal access to comprehensive services (Marmor, Okma & Latham 2005; Mendelsonhn 2002). However, threats are more likely to arise around equity of finance as opposed to equity of access. Existing legislation in Québec mandates all private insurance companies to cover, at a minimum, what is offered under the public drug insurance plan of Régie de l'assurance maladie du Québec (RAMQ) (Government of Québec 2013; Quesnel-Vallée 2013). Indeed, should the current financing strategy proposed by the government be implemented, the ramifications for insurance companies would be two-fold: 1) increases in prescription drug claims due to easier access to health services and; 2) extending coverage to include the new fees charged by pharmacists (Aon Hewitt 2013). The second implication would be inevitable since private insurance companies must cover the same services as RAMQ. Among the main points of contention raised, plan sponsors would experience cost increases, with attendant repercussions on premiums. At the 2011 Canadian Conference on Pharmacy Solutions in Drug Plan Management, private payers raised concerns about increased utilization rates in response to expanding pharmacist services (Felix 2011). Shifting pharmacists' roles from drug dispensers to partners in patient care potentially involves changes to benefit plans such as introducing fee caps as a means to contain costs (Felix 2011). This would likely lead to increased health insurance expenses for both employers and employees. The real source of contention among insurers may therefore be due to the rising costs they face as a result of a reform that potentially facilitates access to services.

The delivery of medically necessary services by health professionals other than physicians is new territory with potentially important ramifications for equity of finance. The expanded role of pharmacists duplicates the medically necessary physician services under the *Canada Health Act*. Yet pharmacist services are beyond the purview of the *Canada Health Act* thereby placing no obligation on governments to provide public coverage. At face value, the reform not only duplicates but also implicitly delists these services based on the health professional that delivers care. In other provinces where the expansion of pharmacist roles has taken place, reimbursement policies differ by service and amount (Amenta 2012; Canadian Pharmacists Association 2014), however no reimbursement for additional services is available to pharmacists in New Brunswick and Newfoundland (Amenta 2012).

Québec is the only province in Canada that mandates universal prescription drug coverage whereby those ineligible for the public plan must be insured privately (Quesnel-Vallée

2013). As of August 2013, government negotiators agreed to only cover the costs for those with public drug insurance coverage through RAMQ, representing roughly 40% of the population. Implicitly, this translates into the other 60% of the population having to finance the costs of the reform either through out-of-pocket payments or higher insurance premiums (Aon Hewitt 2013). Due to the existence of universal drug insurance and the mandated minimum level of coverage offered by private insurance policies to match the public plan, Québec is a unique case of delisting a health service based on insurance status, as opposed to other approaches such as delisting based on location of service delivery. Although this would implicate equity of finance, how it would precisely do so is unclear since subscribers to both public and private plans are subject to premium increases. However, premiums under the public plan depend on annual net family income and are capped, as opposed to payroll contributions for private plans that are negotiated between the policy holder and the insurance company (Régie de l'assurance maladie du Québec 2014a). With concerns mentioned by the Minister of Health for "respecting the government's capacity to pay" (CBC News 2013b) for expanded pharmacist services, it is conceivable that delisting these services based on insurance status is an option that would appease stakeholders but potentially threaten horizontal equity of finance since deductible and co-insurance amounts are determined by private insurers (Régie de l'assurance maladie du Québec 2014b). This may jeopardize equal pay for equal need. Nonetheless, some financial protection is secured since private policy holders are subject to the same annual ceiling amount for out-of-pocket payments as those covered by the public plan (Quesnel-Vallée 2013; Régie de l'assurance maladie du Québec 2014b).

4 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

The implementation of Bill 41 produces strengths, opportunities, weaknesses and threats that vary according to stakeholder interests. Table 1 summarizes potential outcomes of Bill 41, as it was initially proposed by the Minister of Health, from different stakeholder perspectives (public, government, pharmacists, and private insurance companies). Stakeholder perspectives are listed in parentheses.

Table 1: Summary of the potential strengths, opportunities, weakness and threats of Bill 41 as it has initially been proposed by the Ministry of Health

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Increase access to health care (<i>government, pharmacists, public</i>) • Increase utilization of pharmacists' skill set (<i>pharmacists, public</i>) • Potential for continuity of care especially for patients without a regular provider of care (<i>public</i>) • Reduce number of hospitalizations and deaths due to misuse of prescription drugs (<i>government, pharmacists, public</i>) 	<ul style="list-style-type: none"> • Increased costs of private health insurance plans (<i>private insurance companies, public</i>) • No change in health seeking behaviours among those not eligible for public drug coverage (<i>government, public</i>)
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Increase prestige of pharmacists (<i>pharmacists</i>) • Incorporation of pharmacists in team-based models of primary care (<i>pharmacists, patients</i>) • Potential cost-containment strategy (<i>government</i>) • Profit-making opportunity (<i>pharmacists</i>) 	<ul style="list-style-type: none"> • Potential threat to equity of finance if expanded pharmacist services are delisted based on insurance status (<i>public</i>)

5 CONCLUSION

The legislative changes made by Bill 41 to Québec's Health Insurance Act (R.S.Q., c.A-29) allows pharmacists to deliver services that up to now have only been administered by physicians. The explicit aim of these modifications is to increase access to health care. In light of concerns for cost-containment and the potential for delisting medical care making publicly insured services selectively available to some, the reform to expand pharmacist services may potentially produce inequitable financing based on one's public or private health insurance coverage.

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