The Honorable Madeleine Dube
Minister of Health, Government of New Brunswick
Department of Health
PO Box 5100
520 King Street, 6th Floor
Fredericton, New Brunswick
E3B *5GB*

Dear Minister,

As both a pharmacist working in the Greater Moncton Area (Moncton-Dieppe-Riverview) and health-care consumer, I wish to give my support to the Department's stated goal to attenuate the current health-related spending growth. Also, I appreciate the Department's consultation period to allow important input from the public, health professionals and other stakeholders. In order to make Medicare and the New Brunswick Prescription Program more sustainable, we must not only reduce the price of generic medications but also make better use of an important human resource - the community pharmacist. The purpose of my submission is to provide evidence to the Department of the critical value that community pharmacists bring to the health care system.

Canadian community pharmacists are the most trusted professional (1) and are uniquely positioned to provide high-quality and evidence-based pharmaceutical care to the general public. We are the most accessible primary care providers. In order to better serve customers, most pharmacies are open late (some until 9 or 10 PM), on the weekends and holidays. Also, we know how medications, medical supplies and services cost. Importantly, we know how such costs can be reduced when equally effective lower priced alternatives are available (therapeutic substitution).

Additionally, most pharmacies offer home deliveries to mobility-impaired persons and seniors; special packaging for people taking multiple medications or who have adherence problems (e.g.: dementia or Parkinson's disease); compounded medications that are unavailable as commercial products (e.g.: ointments for psoriasis); extensive medication counseling to customers for new prescriptions and follow-up consults to assess efficacy and safety; communicate with prescribers for a multitude of reasons to improve patient care or avoid medication errors (e.g.: contraindications, dosing considerations, allergies, drug interactions); calling back patients to see if they're tolerating their newly prescribed antibiotic or antidepressant.

This is only a short list of all the time-consuming services we routinely provide which are supposed to be payed for, in most part, by dispensing fees and allowances. If these sources of revenue are lost, then pharmacies will be left to limit or charge patients for some services. In the current business model of pharmacies, direct funding (dispensing fee and markup) from third parties and government is inadequately below the actual cost of providing this dispensing

service. To compensate for the loss of revenue after the drug pricing reform, dispensing fees will need to increase and cognitive services will need to be drastically increased. Such cognitive services are where the real savings are to be made.

Since the major mode of treatment of chronic diseases is medications - pharmacists have unparalleled expertise in medications - we are an essential part in achieving optimal patient care. We are uniquely trained to ensure patients take the best medication at the correct dose for their disease; take it correctly; that they know of the benefits and risks of their medications; that they know what to do if they have side-effects; that they know of potential drug interactions; and when to seek a physician's care. Unfortunately, since these services we have been trained for are not adequately funded yet like in some other provinces, New Brunswickers are left with less than ideal pharmaceutical care. Here are some examples of services that we can start to provide immediately if funding is allocated.

From personal experience, I cannot recall how often I have referred a patient to a medical clinic or ER because I suspected the start of a serious skin infection or had severely high blood pressure. As I understand, Tele-Health would get a 30-40$ fee for a situation like this (sometimes they refer to us for a self-limiting condition like minor wounds). On occasion, I would get a prescription for a controlled medication only to find that they're too early, or I have to call every pharmacy in town to see if they've given the same drug. This process is time-consuming, and other jurisdictions have a fee for refusal to fill a prescription. This would add an incentive for us to avoid poly-pharmacy and prevent drug abuse.

Nearly everyday, patients fill a prescription only to be surprise by the high cost of it, or we find that they're allergic to it. If we are able to reach their doctor at that time, we usually can suggest an alternative but most of the time we can't. If we were funded for a pharmaceutical opinion for medication intervention, this would create an incentive to substitute the physician's prescription to an equally-effective medication. Very frequently I interact with patients who take many medications but aren't compliant because they haven't been educated on the importance of taking them as directed. These patients would greatly benefit from having a pharmacist take the time and do a medication management review (Med-Check). Smoking cessation clinics are another excellent way to improve our patients' health and the public in general.

These are only a few of many services that pharmacists can provide. I strongly suggest the Minister's and her consultation committee view Blueprint For Pharmacy website (2) and Canadian Pharmacist Journal to better understand the expanding scope of pharmacy practice, especially the following documents:

- **Expanding Pharmacy Services: Summary of Evidence in Published Literature**
- **Pharmacists' Medication Management Services: Environmental Scan of Canadian and International Services (UPDATED August 2011)**
- **Developing recommendations for the reimbursement of expanded professional pharmacist's services in Ontario (3)**

Lastly, I wish to bring to the Minister and her comitee' attention the opportunities in cost-savings of pharmacist interventions. The following is a very brief review of the recent literature

COST-ANALYSIS STUDIES

Patterson et al. (4) demonstrated that pharmacist interventions, in an adapted U.S. pharmaceutical care model with physician collaboration in Ireland, reduced more than half the number of inappropriate psychoactive medications of nursing home residents and reduces the mean annual health care costs (130$ per patient).

A trial by Look et al. (5) showed that pharmacist interventions consisting of drug therapy changes, switching non-covered drugs and splitting tablets resulted in a mean reduction of 20.31$ and 14.76$ per prescription fill to third party payers and to patients, respectively.

Another U.S. study by Finley et al (6) determined the pharmacist-patient consultations - two or more visits a year for a least 1 year - in ambulatory clinics produced a high rate of retainement (82% followed a pharmacist for a minimum 1 year) and resulted in significant reduction in depression severity and total annual health care cost of more than 1300 $UD per beneficiary.

An economic analysis by American investigators (7) concluded that pharmacist management, specifically interventions related to medication adherence, to be cost-effective and reduced total health care costs compared to projected costs.

In terms of medication management consults to 88 Medicaid benificiaries, Michaels et al. (8) found that about half recommendations made to physicians by US community pharmacists during 4 quarterly medication reviews were accepted, which resulted in total annual net savings (after pharmacist reimbursement) of nearly 3000 $UD.

A large retrospective study by Winston et al. (9) found that medication therapy management services by US community pharmacists resulted in a reduction Medicare (Part D) mean monthly costs 29$USD for in-person consults and 40$USD drug costs for telephone consults, but less for call center consults (15$USD) but not for mail-in education materials.

Sincerely,

Nicolas Basque, Bsc(Pharm), RPh
Moncton, NB
nicobasq@nb.sympatico.ca

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