

# Medical Reform

Newsletter of the Medical Reform Group

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## TIME TO ADD DENTAL CARE TO THE BASKET OF HEALTH CARE SERVICES

Hazel Stewart

*Unlike medical care, access to dental care is not universal in Canada and access varies from province to province. In Ontario, most dental coverage is provided by private insurance, often purchased by employers as a benefit of employment. Dr Hazel Stewart is Toronto Public Health's Dental Director and a longstanding advocate for improved dental access. She works with coalitions who have successfully brought the issue to the forefront in the recent provincial election campaign. The government has pledged to spend \$45 million dollars per year to provide dental coverage to more of Ontario's residents.*

It is undeniable that the mouth, as part of the body contributes to the health and well being of the individual. One cannot be healthy without a healthy mouth. Recent research links poor oral health to other chronic diseases including diabetes, cardiovascular diseases, and respiratory illnesses.

Yet primary oral health care is not included in the services covered by Ontario Health Insurance Plan. Access to primary oral health care is a benefit of employment or wealth.

Many families and individuals who cannot afford dental care go without regular care and seek episodic care. This leads to deterioration in their oral health, loss of vital teeth, and persistent infections from dental caries and gum disease. The presence of persistent infection in a person's mouth may contribute to other more severe infections elsewhere in the body.

Working poor people have the highest burden of oral diseases and the least access to care.

### **Impact of Untreated Oral Disease**

According to a review by Locker and Matear (1), evidence collected from recent research suggests that common oral disorders can have a significant impact on systemic health and the quality of life. Oral diseases affect the well-being of individuals and society as a whole.

The US Surgeon General's Report on Oral Health (2), states that dental decay is one of the most com-

mon diseases in childhood. Among 5 to 17 year-olds, dental decay is five times as common as asthma and seven times as common as hay fever.

### Pain

Pain is a common consequence of oral disease. Canadian studies(3, 4) have indicated that, in a given month, between one third and two-fifths of the population experienced oral or facial pain; between 6 per cent and 9 per cent had pain that was moderately severe to severe; the daily activities of one in seven were affected by this pain (5).

### Functional problems

According to a study by Locker and Miller reporting on the oral health status in an adult population aged 18 years and over 4, 13 per cent were unable to chew a complete range of foods and 10 per cent had problems with speech. Among the elderly, problems with chewing and speech were most common for those

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Editorial committee this issue: Rosana Pellizzari, Gordon Guyatt, Janet Maher

The Medical Reform Group is an organization of physicians, medical students and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. **Health Care is a Right.** The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. **Health is Political and Social in Nature.** Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. **The Institutions of the Health System Must Be Changed.** The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

## EDITORIAL NOTES

*Janet Maher*

**T**his issue features some innovations we hope you will like. This is the first time in recent memory that the main news items have been contributed by friends, not members.

Dr. Hazel Stewart, of Toronto Public Health who has led the charge on improving dental benefits for low income Ontarians, provides a comprehensive overview of the arguments that have been advanced by the public health sector, and seem to have hit the mark with Premier McGuinty. His resolve will likely need to be strengthened in the next few months, as the government begins to move on its anti-poverty agenda.

Consumer advocates Wendy Armstrong and Verna Milligan from Alberta report on some sober second thoughts around the failed Canadian Medical Association resolution on pharmacist prescribing. Their analysis reveals a number of troubling trends in the retail pharmaceutical sector--trends which complement the increasingly aggressive CMA campaign to give credibility and normalize, largely by stealth, the two tier health care approach of the current president and board.

We also report briefly on MRG support for anti-poverty advocacy in Ontario and across the country. Like many others, we have participated actively in the Campaign 2000 coalition activities for the past decade. This coalition traces its roots to a 1989 federal parliamentary resolution marking the resignation of then NDP leader Ed Broadbent, and which expressed the intention of the Parliament to eliminate child poverty by 2000.

Almost 20 years later, the poverty situation has hardly changed, except notably in Newfoundland and Quebec, which adopted provincial poverty reduction strategies shortly after the 2000 deadline.

The 25 in 5 coalition represents a new initiative which brings together social advocates, faith groups and some important allies in the business sector to call on the Ontario government to follow the example of 3 provinces to the east of us to legislate a poverty reduction strategy.

Within the week of the November 29th Throne Speech at the Ontario Legislature, we also saw in Ontario two very important supplementary reports. The United Way of Greater Toronto published *Losing Ground*--documentation of increasing disparities in income in Toronto.

The week following the throne speech, John Stapleton, a long-time policy analyst at the Ministry of Community and Social Services, released *Why is it so tough to get ahead?* It represents the results of an assessment of Ontario income security policy with the sub-head, *How our tangled social programs pathologize the transition to self-reliance* [available for download at [www.metcalffoundation.com](http://www.metcalffoundation.com)].

Another item which members may want to take note of is the work of a Steering Committee bylaw review committee. We are seeking feedback on the recommendations enumerated on page 12, before the committee proceeds with formal resolutions and notice of motion for amendments to be tabled at the annual meeting in spring 2008. ♦

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# TIME TO ADD DENTAL CARE (continued)

without teeth and those wearing dentures.

infection in the institutionalized elderly (11).

cent needed restorations and 10.4 per cent need urgent care (16).

## *Systemic Complications*

◆ Periodontal Disease and Pre Term Low Birth-Weight Babies. Studies in animals and humans have linked oral infection in mothers to pre-term low birth-weight (PLBW) babies. After controlling for other risk factors and covariates, mothers with severe periodontal disease were seven or more times at risk of PLBW (6).

◆ Periodontal Disease and Heart Disease. Prospective studies have found an association between periodontal disease and heart disease

1. A national study of Canadians aged 35 to 69 years found that those with severe gum or periodontal disease had between three to seven times the risk of fatal coronary heart disease (7).

2. Case-control and prospective studies have also suggested that periodontal disease and tooth loss are associated with stroke (8). Adjusted odds ratios ranged from 1.48 to 2.80 indicating that those with poor oral health may have up to three times the risk of stroke.

◆ Periodontal Disease and Respiratory Disease. Poor oral hygiene in residents of long-term care facilities may place them at risk for colonization by respiratory pathogens(9). This is supported by the observation that rates of aspiration pneumonia are higher in those with natural teeth (10). One study reported that poor oral hygiene may be a major risk factor for respiratory tract

## *Oral Health Status and Access to Care*

Poor oral health is concentrated within low income and other disadvantaged groups such as new immigrants and those without dental insurance coverage. The main risk factors for high levels of dental decay (4 or more decayed crown surfaces) were low family income, no visit to a dentist in the last year and no insurance. According to a study in Quebec, the lowest income group had four times the risk of severe disease than the highest income group (13).

Among dentate older adults in Ontario, the lowest income group had fewer teeth, fewer functional pairs of teeth, more decayed crown and root surfaces and more periodontal attachment loss than the highest income group (14). They also had poorer self-perceived oral health, were more likely to report that poor oral health impacted on their quality of life and were more dissatisfied with their oral health status. Over a three-year period 33 per cent of those living in households with an annual income of less than \$20,000 lost one or more teeth compared to 19 per cent of those in households with incomes of \$40,000 or more (15). The former lost on average three times as many teeth as the latter.

Within Ontario, rates of edentulism among those 12 years and older, were 22 per cent in the lowest income group and 5 per cent in the highest income group (12.)

The most disadvantaged group was new immigrants; 22.9 per

## *Dental Insurance Coverage*

The National Population Health Survey of 1996/97 indicated that a considerable proportion (40 per cent) of Ontarians were not covered by private or public dental health insurance plans and programs (17). It is estimated that approximately 20 per cent of the population do not seek dental care, except on an episodic basis, because of lack or inadequate dental insurance and lack of enough disposable income to pay for dental care.

## *The Plight of the Poor*

Working poor individuals are defined as individuals aged 18 to 64 who have worked for pay a minimum of 940 hours in a year, who are not full time students and have a low family income according to the Market Basket of Low Income (When Working is not Enough to Escape Poverty 2006). In addition to having lower wages, working poor individuals typically had jobs offering fewer benefits than other workers. For example, less than 25 per cent of individuals living in a working poor family have access to a dental care plan, while this proportion was close to 75 per cent among individuals living in non-poor families. In Canada households spend on average close to \$1,200 annually on health care with the largest share going to health insurance premiums and dental care.

People without dental insurance and adequate income try to access dental care only when there is an emergency. They usually go to emer-

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# TIME TO ADD DENTAL CARE (continued)

gency rooms in the hospitals, where they get prescriptions for pain relief and infections, are told they need to see the dentist and then discharged.

In addition there are Ontarians for example those in the process of seeking employment and other marginalised groups—people who are under-housed, homeless, mentally ill who are without dental benefits and so are unable to access dental services. Their lack of access to dental care further disadvantages them when trying to regain self sufficiency and independence.

## **Dental Services in Ontario**

There is a lack of policy on the provision of dental care in Ontario. So benefits for residents with private insurance, vary from 40 per cent to 100 per cent of a fee guide. The fee guide on which the benefits are based may be out of date. The employee is responsible for paying the difference in fees. In large families with benefits, paying the extra billing fees may be prohibitive to accessing dental care.

The Ontario Works dental program for dependents age 0-18 years, is cost shared 80:20 by the Province and Municipalities. This program is province wide, is a fee-for-service and is administered by municipalities.

The Children in Need of Treatment (CINOT) Dental Program for children (0 – 14 years or Grade 8) of working poor families is cost shared 75:25 by the Province and Municipalities. This program is province-wide, is fee-for-service and is administered by local public health agencies.

For children who are in the foster-care system there are a variety

of models for providing care. These models include volunteer dentists, fee for service, and clinics owned and operated by the agency. For example Jewish Family Services uses a volunteer model, Catholic Children's Aid uses a fee for service model and Children's Aid has operated their own clinic for 30-35 years.

Dental services for adult recipients of Ontario Works are discretionary programs with the level of coverage determined by the municipalities. So there is a range of benefits across the Province, from no benefits, to emergency only, to basic care. Where municipalities provide dental benefits there are different models of care. Some municipalities, for example Ottawa, have their own dental clinics while other municipalities for example Toronto, have a fee for service model.

Dental Services for people on The Ontario Disability Services Plan are funded 100 per cent by the Province and is a fee for service model of care.

In some municipalities there are small municipally funded programs to assist the neediest. In these municipalities these programs are mainly targeted at adolescents and seniors who are in dire need.

In addition there are approximately 10 coalitions comprised of health and social services agencies, and service clubs, who use a variety of fund raising means to assist some of the neediest in their communities. Some coalitions run clinics using volunteer dental staff. Volunteer clinics have difficulty attracting volunteers and raising enough to sustain these clinics. Service to the community is therefore unpredictable.

Toronto Public Health, (TPH) the largest municipality, in addition to administering the provincially mandated programs for children offers dental services in 14 community clinics. Those who are eligible for the TPH program include children and adolescents in low income families who are not eligible for provincial programs, low income seniors 65 years and older, parents enrolled in some public health programs.

The evolution of dental care for residents of Ontario, who are underprivileged, has been a mix of government funding and health and social service agencies and clubs response to local needs. Therefore, there is an infrastructure that exists in some municipalities to provide dental care to those in greatest need. With additional investments, these infrastructures could become sustainable entities for the provision of dental care for vulnerable groups.

In areas where no infrastructure exists funding should be provided to agencies in those communities to develop models of care that are suitable for those communities.

## **Options to Provide Care/Improve Access to Care**

1. Standardize the services covered under Government Funded programs.
2. Extend CINOT/OW Programs to cover age groups not currently covered.
3. Include dental services in the list of primary health care services covered in Community Health Centres and other agencies serving marginalised groups.

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# TIME TO ADD DENTAL CARE (continued)

4. Public-private partnerships between Public Health Units, Community Health Centres, other stakeholders, including private dentists and hygienists at the local level to improve access and case management.

## **RECOMMENDATIONS**

The Ontario Coalitions are recommending the following:

1. The Ontario Government standardise the services covered under government funded programs.
2. That an effective community oral health education -prevention component be included in the program.
3. Funding is provided for local public health units, in partnership with local health and social service agencies including community health centres, to develop models of care in their local municipalities to provide dental services that are accessible, affordable, and sustainable. These services are targeted to the neediest residents.
4. That there are accountability measures associated with the funding to ensure the neediest residents are receiving the services.
5. That the different models of care be evaluated to inform decision makers.
6. That the Ontario government develops policies to ensure access to primary oral health care for those who who do not have access because of finances

It must be recognised that there is a backlog of dental needs province wide. So unless there is a major infusion of funding, it will take several years to improve the oral health status of Ontarians. In the early stages of any dental program it should be anticipated that most of the funding may be used to relieve pain and infection and replace teeth in those individuals who are edentulous. Since the most common forms of oral diseases, dental caries and gum disease, are preventable, the Coalitions are recommending that community oral health promotion and prevention programs are strengthened province-wide.

Ontarians recognise the importance of oral health and access to dental services. However, because of the lack of clear policy and appropriate funding there has been no systematic method of ensuring access to primary oral health care, especially for the most vulnerable people in our communities. This situation is intolerable. We should no longer accept that it is okay for people to endure pain and infection, just because the pain and infection is in their mouths. ♦

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# A POVERTY ELIMINATION STRATEGY FOR ONTARIO

*Steering Committee member Rosana Pellizzari signed a November 21, 2007 letter to Ontario Premier McGuinty, Minister of Health and Long Term Care Smitherman, Minister of Health Promotion Best and Minister of Children and Youth Services and Women's Issues Matthews*

**A**s a supporter of efforts to end poverty in Ontario, the Medical Reform Group looks forward to hearing further detail in the November 29<sup>th</sup> Throne Speech about your government's commitment to a **Poverty Reduction Strategy for Ontario**.

We will be looking specifically to hear more about the government's commitment to poverty reduction and your plans regarding on **targets, consultations, policies** and **resources for this important undertaking**.

As we know from other jurisdictions, setting and tracking **targets** is critical to following through on good intentions. Many in the province have called for poverty reduction targets of minimum 25 per cent in your current mandate and 50 per cent within the decade.

We also look forward to hearing about your plans to **consult** with Ontarians about what should be included in a poverty reduction plan. Low income people, community and civic leaders, policy thinkers, and business representatives, all need to be involved in discussions about the kinds of **policies** that will make a difference to people living in poverty in this province. We think the following four priorities will be essential:

- ◆ Start with the principle that a hard day's work should equal a fair day's pay, through minimum wage increases and stepping up the enforcement of labour standards.
- ◆ Give families real income security by bolstering the newly created Ontario Child Benefit and providing adequate systems of support for those who cannot work full time.
- ◆ Make affordable housing and quality child care top provincial priorities, and ensure that everyone in our society has real access to medical and dental care.
- ◆ Finally, good intentions and a great plan will remain stalled unless backed by significant **resources**.

I and my colleagues will be listening to the November 29<sup>th</sup> Throne Speech for an important signal of the Ontario government's commitment to fulfill your election promise to make poverty reduction a priority in this mandate. ◆

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## TIME TO ADD DENTAL CARE (continued)

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# PHARMACIST PRESCRIBING: WHAT'S BELOW THE WATER LINE?

Wendy Armstrong and Verna Milligan

Last summer, the Canadian Medical Association (CMA) passed a resolution at their annual convention recommending that pharmacists “not be given independent prescribing authority” as part of a series of resolutions related to new collaborative practice models.

Reaction was swift and hard. Reform-minded physicians, nurses and pharmacists across Canada were quick to condemn the CMA delegates as paternalistic, paranoid and motivated by turf protection. Others suggested the resolution struck at the heart of new collaborative practice models being championed and implemented across the country.

But was this really the case?

A careful look at international trends in expanding prescribing authority to other professions, the changing nature of the retail pharmacy sector in North America and liberalization of drug regulatory regimes suggest there may be more “below the water line” than first meets the eye.

Instead of limiting harm from the growing “medicalization” and the influence of the pharmaceutical industry on prescribing decisions, independent pharmacist prescribing may well exacerbate these trends.

## Background

For years, public opinion surveys in Canada have consistently ranked pharmacists as one of the most trusted health professions. While about 15 per cent of pharmacists work in a hospital or other integrated care setting, 80 per cent work

in the retail sector.

Retail pharmacists fulfill an essential service, dispensing and selling medications, providing an important second safety check on prescribing decisions and advising on over-the-counter drugs. Their knowledge and training also enables them to advise other health professionals about the therapeutic value and hazards of drugs and how to resolve drug-related problems.

In recent years the demonstrated value of pharmacists working as part of clinical teams in hospitals and other integrated care settings has led to growing support for integrating pharmacists in new primary care initiatives under the public Medicare umbrella. Along with calls for an expanded presence of pharmacists in new primary care settings, there has also been a parallel push by pharmacy leaders to expand the *scope of practice* of pharmacists in retail pharmacy settings, and thus the role of retail pharmacy sector in the provision of health care services.

Driven by both job dissatisfaction related to increasing administration burdens and fears of being replaced by new dispensing technologies and lower cost pharmacy technicians, pharmacists have lobbied to expand their scope of practice and opportunities for billing for professional services,

Promoted as a way to alleviate the burden on doctors and hospitals, save the public health system money, and save patients’ valuable time, retail pharmacies and pharmacists have advocated moving a number of optional services into

pharmacy settings. Examples include on-site screening, monitoring of lab values and independent management of chronic health conditions as well as immunizations and treatment of minor short-term conditions.

In order to operationalize such changes, pharmacists would require independent prescribing authority, the ability to provide injections, and access to patients’ medical files and history.

After many years of lobbying, efforts finally paid off. As of April 1st, 2007, a new Pharmacists Professions Regulation under the Alberta’s Health Profession Act gave Alberta’s 3700 pharmacists independent prescribing authority. It also gave Alberta pharmacists the broadest scope of practice in North America and among the broadest in the world.

Over the past decade, Alberta has led the way in Canada in giving an ever-growing list of health professions prescribing authority. Nine regulated health professions, including physicians, dentists, dental hygienists, optometrists, dietitians, midwives, nurse practitioners, podiatrists and pharmacists now have full or limited prescribing authority. Alberta has also led the way with a universal electronic health record, NetCare, expected to be fully operational by 2008.

Because diagnosing is not a restricted activity in Alberta, pharmacist prescribing is not linked to diagnosis. Therefore, as well as increasing Alberta pharmacists’ professional latitude to do temporary refills and make minor adaptations - similar to

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# PHARMACIST PRESCRIBING (continued)

that of pharmacists in BC and Ontario - the new regulation greatly expanded other types of prescribing,

Following completion of a 3-hour orientation to new practice standards, Alberta pharmacists can now independently adapt the dose, formulation and regimen of prescriptions, renew prescriptions, and prescribe in an emergency – if they are comfortable doing so. Those who complete extra courses are also allowed to initiate therapy and manage chronic conditions such as asthma, diabetes, high blood pressure and high cholesterol and give injectable drugs such as vaccines. More than 90 per cent of Alberta pharmacists have now completed the 3-hour orientation.

Given former restrictions and a decade of patients being forced to either visit their doctor or pay physicians \$10 to \$25 dollars for once-free telephone renewals, the public largely welcomed these changes. All the Opposition parties supported these changes, considering them part of long-standing policies supporting all professions being allowed to work to the full scope of their training. Nurses supported these changes. Editorial boards were enthusiastic.

Even Albertans, who, for over a decade, worked tirelessly against the erosion of public Medicare saw little cause to complain about such an expanded role for the retail pharmacy sector.

The only voice of caution other than some physicians came from the Alberta Chapter of the Consumers' Association of Canada. It weighed in with concerns about safety, loss of confidentiality and accrued costs to consumers as a consequence of moving basic health services into such a commercially oriented

environment. In particular, the association was concerned with the inherent conflict-of-interest arising from corporate pharmacy owners being in a position to profit from prescribing by in-house pharmacists in addition to sales of prescription drugs. Given its research and experience as well as historic prohibitions on physicians profiting from sales of prescribed products in order to avoid bias, it said it seriously questioned a number of assumptions about the benefits of enhanced prescribing powers and anticipated uses.

With current challenges accessing family physicians, the occupational blinders of many well-intended pharmacists, and the widespread enthusiasm for “health promotion” initiatives by policy makers, these concerns fell on deaf ears. Other provincial governments are also looking at expanding the scope of practice and prescribing powers of pharmacists.

*However, mixing this new commercial health cocktail with a hefty dose of innocence and occupational blinders may lead to far more than the public or pharmacists ever bargained for.*

## **What's Below the Water Line?**

The trend to expanding scopes of practice for pharmacists and other health professions, including expanded prescribing authority is not unique to Canada. Neither is the trend to increased reliance on the retail pharmacy sector to provide an expanding array of health care services.

Both are part of multi-pronged government strategies aimed at increasing public access to medications, ironically at time when many observers suggest that growing overuse of medications repre-

sents a serious threat to the health of populations is.

## **Getting your health care at Wal-Mart**

Retailers, chain drugstores and pharmaceutical companies have been eager to exploit the expanding prescribing powers of professions other than physicians in both the U.K and the U.S.

In the U.S. many large pharmacy chains and mass merchandisers such as Walgreens and Wal-Mart have gotten into the business of offering on-site clinics staffed with prescribing nurse practitioners and physician assistants.

According to the *Drug Store News* web site <http://www.retailclinician.com/>, “These clinics are already serving thousands of patients for minor ailments and common illness such as colds, coughs, upper respiratory infections, skin conditions, pinkeye and more. Many also offer diagnostic screenings for conditions such as diabetes and most offer vaccinations.” Currently staffed by prescribing nurse practitioners and physician assistants, it is anticipated there will be 3000 to 3500 of these clinics by the end of 2007, with even greater opportunities for expansion as a number of states also approve independent prescribing for pharmacists.

The clinics provide opportunities for increased profits from enhanced sales of prescription and counter drugs: 70 per cent of users represent a new drug customer. Thirty-eight percent of patients purchase an over-the-counter product and 60 per cent receiving a script. Of those who receive a script, 95 per cent fill the prescription in the store.

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# PHARMACIST PRESCRIBING (continued)

While this trend offers significant opportunities for profiting from sales in the pharmacy section of these retailing giants, even greater profits can be had from getting customers in the door to purchase other products and services. Customers waiting to see a clinician or have a script filled are given a pager so they can wander around the store while they wait. Competing offers of \$4 prescriptions and “free antibiotics” among mass merchandisers and pharmacy chains are more than offset by spending on groceries, cosmetics, and other retail purchases.

## ***The English Patient***

Britain is often held up as an example of success in both supplementary and independent prescribing by pharmacists and nurses, but again there is much below the water line.

Critics have raised concerns about the potential undesirable effects of these initiatives. Identified undesirable effects range from loss of the quality and availability of core pharmacy services and increased fragmentation of care to new barriers to safe prescribing and more reliance on medications rather than non-pharmaceutical approaches to care. It also questions the safety of increased reliance on lab values and on-site lab testing in lieu of physical assessments, a hallmark of these new prescribing practices.

In the UK, pharmacists and nurses have gone from supplementary to independent prescribing within three years – from 2003 to 2006, and much of the language has shifted from collaboration to competition. Care has also been diverted from NHS settings to large retail pharmacies such as Boots. Some observers have suggested these

changes are little more than back-door privatization of the NHS that will come at significant cost to British taxpayers, patients and employers. While – as suggested by a 2006 study of the experiences of supplementary prescribers in Britain – supplementary prescribing can be beneficial in collaborative practice settings under the NHS, its benefits in other settings are far more questionable.

## ***The changing face of retail pharmacy in Canada***

Similar to the U.S., the retail pharmacy sector in Canada is undergoing a metamorphosis, moving from stand-alone owner-operated drug stores to “one-stop shopping” grocery and retail pharmacy chains. Mergers and acquisitions are ongoing. Large chains such as Rexall and Shoppers Drug Mart are re-inventing themselves and going head to head with mass merchandisers such as Wal-Mart and Safeway competing for consumer dollars, inside and outside the pharmacy section.

Many also operate their own supply and distribution networks. Similar to strategies employed south of the border, retailers are promoting new pharmacy services such as in-store screening, awareness days, clinic days and disease and wellness programs to pull more people into their stores. Some are also offering outreach services to peoples’ homes, albeit at a hefty price.

And there is “gold in them thar hills.” A November 10th Globe and Mail article (A hard act to follow) reported that, across the sector, customers who come to fill a prescription spend twice as much (\$58) in the rest of the store as those who only go to pick up cough drops or toothpaste in the front of the store.

Other strategies being employed by pharmacy chains competing with large mass merchandisers such as Wal-Mart include offering more convenient locations, more spacious stores, speciality departments within stores and being open 24 hours.

## ***Growing the Pharmaceutical Pie***

The nature, extent and consequences of physician relationships with the drug industry have become one of the most fiercely debated issues in health care today. There is ample evidence these relationships can adversely affect research, clinical practices and patient outcomes.

In contrast, there has been little focus on the largely inscrutable world of commercial pharmacies. Just what is the relationship between pharmacists, pharmacy faculties, retail pharmacy interests and drug manufacturers? How might these relationships and economic incentives influence the safety and quality of pharmacist prescribing and treatment recommendations in retail settings?

A quick peek at the trade literature and industry web sites such as Eyeforpharma and Drug Store News suggests a need for caution and scrutiny. So does a recent report by the Competition Bureau of Canada revealing how current arrangements between generic drug companies and retail pharmacies have not worked in the best interests of consumers.

Representatives from the National Association of Drug Stores in the U.S. recently met with the CEOs of a number of pharmaceutical manufacturing companies to review cross-sector opportunities for “growing the entire pharmaceutical pie.” One identified strategy was to team up to offer more screening pro-

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# PHARMACIST PRESCRIBING (continued)

grams. Another was to facilitate the implementation of E-prescribing to enhance compliance by using reminders to capture the 20 per cent of scripts that are never filled and a 40 per cent failure-rate by seniors to renew prescriptions.

Other industry literature reinforces the value of such strategies. For example, with support from Pfizer, the National Community Pharmacists Association in the U.S. developed a health risk assessment tool for use with male customers of pharmacies and tested this tool in thirty pharmacies across the country. On average 3.1 health risks were identified for each man screened. Almost 2/3 followed up with their doctors as suggested by the pharmacist, and of those who did, 82 new prescriptions were generated for every 100 men who visited their physicians.

Much of the impetus for pharmacist prescribing in Alberta has been supported by studies, papers and documents produced by COMPRIS, the Centre for Community Pharmacy Research and Interdisciplinary Strategies) at the University of Alberta. Listed sponsors for the centre are Apotex Canada, AstraZeneca Canada, Bayer HealthCare Pharmaceuticals, Bristol-Meyer Squibb/Sanofi-Aventis, Overwaitea Food Group and ManthaMed, a distributor of diagnostic and point-of-care management tools. The centre focuses on expanding opportunities for retail pharmacies to identify and manage under-diagnosed and undertreated patients, including the use of pharmacy customer drug profiles and electronic records to identify potential candidates. A recent report, *Prescribing Pharmacists: An Emerging Decision Maker*, by Kalorama information, a business intelligence service predicts

that with 6 more states moving to independent pharmacist prescribing as well as Florida, it suggests pharmaceutical revenues influenced by pharmacists could grow from \$77 billion in 2006 to \$145 billion by 2012.

## **Questions yet to be answered**

Before other provinces, pharmacists in other pharmacists and the Canadian public jump on this bandwagon, it may be wise to ask some questions.

Who will pay for all these pharmacy-based assessment and prescribing services – and how much? How will it affect the safe prescribing and use of medications? Will there be an increased focus on drug therapies rather than other treatment alternatives? Will the quality of prescribing and counter drugs use increase or decrease? Will electronic medical records be used by pharmacies for surveillance and marketing purposes as well as clinical decision-making? How will the patients and the public tell the difference between marketing and health promotion?

Who will be minding the store and honestly reporting on the outcomes of these changes? If retail pharmacy outlets are allowed to market and profit from sales of both professional services and associated products, will physicians and hospitals demand to be allowed to the same? Should there be different scopes of practice and prescribing frameworks in different settings?

Perhaps the CMA delegates weren't as "off base" as many imagined. ♦

*Wendy Armstorng is a health policy analyst and advocate for consumer organizations, including the Alberta chapter of the Consumers' Association of Canada. Verna Milligan is a retired concerned citizen.*

## **Resources on Drug Issues**

### **Industry News**

Eye For Pharma:

[socialeyeeforpharma.com](http://socialeyeeforpharma.com)

Drug Store News:

[www.drugstorenews.com](http://www.drugstorenews.com)

Canadian Association of Chain Drugstores:

[www.cacds.com](http://www.cacds.com)

### **Consumer Drug Safety Groups**

Women and Health Protection:

[www.whp-apsf.ca](http://www.whp-apsf.ca)

Health Action International:

[www.haiweb.org](http://www.haiweb.org)

Which? (British):

[www.which.co.uk](http://www.which.co.uk)

Public Citizen:

[www.citizen.org](http://www.citizen.org) and  
[www.worstpills.org](http://www.worstpills.org)

### **Regulators of Retail Pharmacies:**

See NAPRA for provincial contacts:

[www.napra.org](http://www.napra.org)

# TIME FOR POVERTY REDUCTION IN ONTARIO

Janet Maher

The Medical Reform Group joined many other advocates in the recent Ontario election campaign in calling for 25 in 5. Having seen the success of dedicated strategies with clear targets, timetables, and resources in the United Kingdom, Ireland, and impressive efforts in 3 Canadian provinces (Newfoundland,

Nova Scotia and Quebec), the Ontario advocates called for a 25 per cent reduction in poverty in the next five years.

Although no party stepped up to the challenge at election time, the majority Liberals did signal in the November 29th Throne Speech their intention to 'begin work developing

poverty indicators and targets and a focused strategy for making clear cut progress on reducing child poverty.

It will be our job to ensure that they understand clearly that a real poverty strategy ensures that children are not born to poverty because their families get the resources they need to succeed and live in dignity. ♦

## MRG MEMBERSHIP APPLICATION

I would like to ☐ become a member ☐ renew my support for the work of the Medical Reform Group

### Membership Fees

- \$245 Supporting Member Physician
- \$60 Affiliate (out of province) physician Intern / Resident / Retired / Part-time Organization
- Free Newsletter Subscriber E-Newsletter Subscriber Medical Student / Medical Research Student

Please specify membership category:

Please specify areas of interest and expertise:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Province \_\_\_\_\_  
Telephone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-mail \_\_\_\_\_

Please charge my MasterCard/VISA in the amount \$ \_\_\_\_\_. My credit card account number is: \_\_\_\_\_  
Name of Card holder: \_\_\_\_\_  
Expiry Date: \_\_\_\_\_

Mailing Address:  
Medical Reform Group  
Box 40074  
Toronto, ON, M6B 4K4

If you prefer, you may pay your membership fees and supporting contributions through our monthly payment option by completing the following authorization and enclosing a black cheque, marked "VOID" from your appropriate chequing account. I authorize my financial institution to make the following electronic payments directly from my account:  
The amount of \$\_\_\_\_\_ on the first day of each month, beginning \_\_\_\_\_, 20\_\_\_\_.  
Please credit the payments to the Alterna Savings and Credit Union account (No. 1148590) of the Medical Reform Group. I understand that these electronic payments will continue until I give notice in writing to the Payee to stop doing so; that I must notify the Payee in writing of any changes to the information in the authorization; and that I must notify the Payee within 90 days of any error in the electronic payment.

Account holder's name (print)

Account holder's signature

Date

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# MRG BYLAW REVIEW

**L**ikely the MRG constitution is honoured as much in the breach in the observance, an issue the current Steering Committee agreed to take under advisement by appointing an ad hoc committee for the purpose earlier this fall.

The committee, comprising Rosana Pellizzari, Norman Kalant and Andrew Pinto came up with several revisions which are intended to reflect better our current or recent practice. What this means, for example, is eliminating references to regional steering committees; and clarifying and reducing inconsistencies between articles in the provisions for meeting notice and voting procedures.

Among the committee recommendations are three to be presented for membership comment and feedback, before formal submission for debate at the Spring 2008 Annual Meeting:

1. ***Eliminate the requirement***

***for a fall semi-annual meeting.***

This is normally an educational session, held in late October or November, not always an easy date for busy people. Eliminating the requirement would not necessarily preclude convening an educational meeting as interest or circumstances dictate.

2. ***Reconstitute the Steering Committee***

to include a minimum of seven members, including at least one student. This is a change from twelve in the bylaw last reviewed in 1983. The committee recommendation is for a usual term of office of three years.

3. ***Design and implement a plan for electronic polling***

on issues of concern to the membership. While e-mail votes or audio or video conferencing might not be the most effective use of resources for educational discussions, decision-making on a specific issue or set of issues can take advantage of

current technology and would allow for broader membership participation than has been the case.

Members also gave attention to the statement of principles and will be preparing revisions to the statement which more closely reflect current concerns. The current statement is featured on the MRG website at [www.medicalreformgroup.ca](http://www.medicalreformgroup.ca).

The process proposed for entertaining the amendments is that a short summary be posted in the newsletter, along with an invitation to members to respond with comments to the steering committee through the office by the time of the January 2008 steering committee. The Steering Committee will compile and circulate detailed amendments in time to meet the most stringent notice requirements from the 1983 bylaw (30 days).

For more information and draft revised materials, contact [medicalreform@sympatico.ca](mailto:medicalreform@sympatico.ca) ♦

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