Ontario College of Pharmacists
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OCP response to the second consultation by the Ministry of Finance on a framework to regulate pharmacy Preferred Provider Networks in group insurance plans

July 28, 2025

Executive Summary

Since 2018, the Ontario College of Pharmacists ("OCP" or "the College") has expressed a number of concerns associated with pharmacy participation in closed Preferred Provider Networks (PPNs), including increased risk of fragmented and diminished continuity of care, access inequities, reduced patient autonomy, and the subsequent effect these can have on the delivery of consistently safe care to Ontarians. In March 2024, the College re-ignited the conversation about PPNs and in July of the same year established a zero-tolerance position that articulates the nature of the regulatory concerns associated with such arrangements.

Over the past year, the Ministry of Finance, in collaboration with the Ministry of Health, has engaged a broad range of health system partners including the College to explore possible solutions to these concerns in a manner that achieves a set of broader policy goals established by the government. The College has appreciated the opportunity to provide input to date, and we are pleased that the government continues to seek our input not just as the pharmacy regulator, but as a partner and long-time trusted advisor to the government on matters concerning the delivery of safe, quality and ethical pharmacy services to Ontarians.

The Ministry of Finance is now inviting feedback on specific proposals included in a second public consultation on PPNs. As the pharmacy regulator, the College is best positioned to inform the government on what changes or other measures are needed in their proposals to satisfy the well-established concerns that have been expressed about restrictive PPN arrangements and their impact on pharmacy patients, while ensuring Ontarians continue to have timely and reliable access to affordable medicines.

The OCP Board of Directors, which remains ready and committed to considering regulatory policy options that are within the College's oversight authority, has prioritized providing input to the government toward an outcome that puts patients first. Accordingly, in its response to the latest government consultation on PPNs, the College:

- Suggests ways to strengthen the proposals and for the College to play a key role in either or both of those models, whether by informing or setting transparent terms and rules of such models, or by taking on a broader oversight role to ensure that they are in the public interest and that they maximize patient autonomy and informed consent, continuity and safety of care, and equitable access to pharmacies and affordable medicines;

- Emphasizes the importance of maintaining the Standards of Practice and Standards of Operation as well as the Code of Ethics in any such rulemaking related to how either model would be implemented with effective oversight that reinforces the integrity of pharmacists as healthcare professionals who are entrusted with always making decisions in the patient's best interests; and,

- Makes clear that additional information is needed to ensure that regulators, system partners and the public can make fully informed contributions to the government's decision-making related to either model and their implementation.

Whatever the approach the government chooses to move forward with, it will be imperative that the solution directly addresses the concerns raised by the College and that our role as a regulator with authority to hold pharmacies and registrants accountable to the established expectations of the profession – expectations that underpin the public's trust in pharmacy – are firmly integrated into the final approach. We very much look forward to continuing to engage with the government constructively and collaboratively towards the best solution that leads to the desired outcomes of both the regulator and government, and we are hopeful that this remains an achievable goal.

Responses to Consultation Questions

General Questions pertaining to both options:

1. Should PPNs be expressly restricted to specialty medication? If so, what is the appropriate definition for specialty medication?

In Canada, the legislative and regulatory framework that governs medications does not include a definition of "specialty medication". Currently, insurers use this term to capture a range of factors, such as the cost of the medication, the relative "rarity" of the condition or disease being treated, and the method of administration or the level of monitoring a patient requires, among other factors.

The specific medications which are available to be dispensed according to a valid prescription may vary by pharmacy, but the term "specialty" is not required for medications that can be dispensed by a registered pharmacist in an accredited pharmacy. Restricting PPN agreements to "specialty medications" would require the Ministry to define the parameters of what would be considered "specialty". However, there are potential risks in doing so and restricting PPNs to "specialty medication" may not lead to the elimination of the identified concerns the College has raised to date.

For example, if a patient who has been prescribed a medication defined as "specialty" is required to have that medication dispensed at a network pharmacy, but who has all of their other "non-specialty" medication at another pharmacy, associated potential risks include (but are not limited to): fragmented delivery of care, documentation, administrative processes; increased risk of medication incidents including errors that reach the patient; and additional and unreasonable burden on all parties as a result of having to navigate care involving multiple pharmacies.

As well, given the lack of a consistent, transparent, and generally accepted definition of "specialty medication", there is some concern that insurers and intermediaries such as pharmacy benefit managers may begin to define medications as "specialty" to justify placement of certain medications under a network pharmacy that had previously not been restricted to PPNs. Such a scenario could further erode public trust in any such model and would only exacerbate the College's stated concerns. Further discussion with the Ministry would be welcomed if it considers moving forward in this direction.

2. Which of the two potential regulatory options – Any Able and Willing Provider or Standardized Mandatory Exemption – would best promote:
   a. Improved health outcomes (including continuity of care)?
   b. Affordable coverage of specialty medication?
   c. Consumer choice?

The College has found limited publicly available and objective information on whether either of the models would improve health outcomes or increase the affordability of medications generally. In the absence of robust, objective and clear evidence, the College is unable to advise on whether either of the models presented achieves those goals other than to reiterate the risks to safe and quality patient care associated with such models continue to be reported and shared with us from members of the public as well as the profession and to reinforce that access to affordable medicine must be preserved.

Without necessary patient-centred safeguards, we believe that risks will remain with any agreement that does not permit patients from accessing their medications from a pharmacy of their choice or respect the principles of informed consent, or that interferes with the delivery of timely, safe, equitable, unfragmented and ethical care. While the College recognizes that there are other system partners that may find a model such as Any Able and Willing Provider as holding the most promise, it may not address all of the concerns identified by the College without further adjustments to either or both proposed models. The College strongly believes it can play a role in those adjustments.

Standardized Mandatory Exemption (SME)
It is the College's understanding that the elements of this model that are focused on access would allow mandatory exemptions to be set for equity-deserving individuals, populations, and communities who will be able to receive care from their pharmacy of choice regardless of whether the pharmacy is in or out of a network. However, there is an absence of robust, transparent research involving SME models to inform an in-depth understanding about the development and implementation of such an approach. Based on the limited objective information the College has obtained, there remain numerous unknowns about this option which make it difficult to determine with any certainty what impact it will have on equity, access, ethical decision making and patient autonomy.

For example, it is unclear to the College how exemptions will be determined and how they will be consistently applied in practice, and how equity-deserving patients will be guaranteed access to their preferred pharmacy if they cannot "prove" they are eligible for an exemption. And while the SME model may work for patients who have exemptions, there is a concern that it may leave patients without an exemption at risk of being steered to a pharmacy not of their choosing or without their informed consent, thus still posing patient care concerns.

However, the College can play an important role in defining and overseeing the exemptions that ought to be considered to ensure that this is done in a way that is in keeping with our public-interest mandate and the established operational and practice standards and ethical obligations relevant to the profession. The College possesses well-established mechanisms to engage the profession broadly, as well as the public, in open consultations to hear directly from care providers and from patients to inform a path forward that reflects input from those most impacted by such an approach.

Any Able and Willing Provider (AAWP)
The College understands this approach to be about enabling more or any pharmacy to participate in a network if they are able to, are willing to and thus agree to do so. However, the terms "able" and "willing" are not defined, and would need to be clearly articulated and made transparent for the public to understand the decisions being made that ultimately impact their ability to choose their pharmacy and that such criteria are reasonable for pharmacies to meet.

The College welcomes the opportunity to collaborate with government on how such a model is structured, planned and implemented. For example, if the College were to be involved in setting and enforcing the types of terms and conditions associated with AAWP, including ensuring that such terms are transparent, reasonable and relevant to the delivery of quality patient care, then it may be possible to establish such terms that make it possible for the greatest possible number of pharmacies to participate, thereby further increasing the chances that patient autonomy, and the associated benefits of greater continuity of care and access, can be better safeguarded.

In such a role, the College would be guided by its existing authority and powers and would approach AAWP terms from a principle that would maximize patient autonomy, promote greater provisions related to informed consent, and promote improved access and continuity of care in keeping with established standards and ethical expectations. This may render the "able and willing" description of this model to be more open than what it currently appears to be in the Ministry's consultation. How this balances with the government's policy goals is uncertain, and any approach must remain alive to avoiding unintended consequences such as a reduction in affordable access to medications, including those defined as "specialty".

3. Should the two options be seen as mutually exclusive or complementary?

While the College believes that it may be able to play a role in how either model is further developed and implemented, it is possible that the implementation of both options, in a complementary model, could address more of the College's concerns than if only one model is implemented.

Based on the College's understanding, a complementary model suggests that patients with exemptions and those who have pharmacies in the network could be subjected to less fractured pharmacy experiences. The College could play an important role in setting terms and conditions for participating in an AAWP model, as well as defining and monitoring the implementation of SME-based exemptions that place patients at the centre of that kind of decision-making, while ensuring that the standards and Code of Ethics of the profession remain the basis for guiding principles.

This might give a maximum degree of 'public protection' from the concerns associated with PPNs to date, but this would need to be further tested in detail by the regulator as it is unclear whether the government's policy options and the approach the College would wish to take are congruent and workable without further discussion with the Ministry of Finance, collaboratively with the Ministry of Health.

4. Which policy option would be most appropriate for Ontario? Is there another alternative which may better balance the key policy objectives?

While both may hold some potential, neither policy option, at the moment based on information available to the College, adequately addresses the College's commitment to patient-centred care without clarity on core safeguards, including those that may be established by the College.

Under the province's *Your Health: A Plan for Connected and Convenient Care,* the plan describes the importance of patients' accessing their local pharmacy and acknowledges that when individuals have "health care available in their communities, and in ways that are convenient for them, [they] are more likely to seek and receive the treatment they need when they need it and stay healthier". In addition, patient choice is codified in Ontario's *Health Care Consent Act, 1996* which assures that all patients have the information required to make the best decision they can about their health care. The College's focus on patient autonomy is supported by the Ministry of Health's commitment to patient-centred care and calls for a policy option that assures equitable access to pharmacy care at the pharmacy of choice for Ontarians.

The College is interested in understanding how it may be able to work with the Ministry towards the implementation of policy options that are in the best interest of Ontarians and how best to optimize these options to mitigate risk of systemic inequities in access to care, reduced patient autonomy and fragmented care. By taking on a role in defining, monitoring and overseeing how either model is implemented, the College may be able to strengthen the approach overall in keeping with its existing regulatory authority; however, it may need to have additional authority established or clarified in regulation, and reinforced in policy, to take on expanded oversight roles to ensure it can be implemented successfully. This concept, along with the specific mechanism to achieve the College's goals satisfactorily, requires additional exploration.

5. During the initial consultation, some PPN operators indicated that certain pharmacy categories should be included in all pharmacy PPNs by default (such as those within Oncology Centres of Excellence and pharmacies located on hospital premises).
   a. Is this an appropriate approach?
   b. If so, what categories of pharmacies should be included?

As the regulator of pharmacies, the College issues certificates of accreditation to all pharmacies that meet the requirements set out in legislation and in our Standards of Operation, regardless of the setting or the service provided. While the College has the authority to define specific standards and requirements that may be tied to the delivery of specific services where it is in the public interest to do so, there are no special designations as it relates to classes of pharmacy certificates of accreditation. Moving forward with an approach that relies on the existence of designated "types" of pharmacies being required to be a part of a PPN agreement may negatively impact patient access, choice and continuity, unless perhaps protected in some way by an SME-like scheme.

For example, we can contemplate a patient needing oncology medication (regardless of whether it is deemed a "specialty medication") and being required to use a specific pharmacy, such as in a hospital, that is considered a "Centre of Excellence" and thus part of a network. Unless the number of such centres is widened significantly, the patient may be faced with having challenges accessing those pharmacies due to geographic limitations if their local preferred pharmacy, as an example, is not part of the network and thus the patient faces barriers accessing their medication in a timely, effective and safe manner.

In this type of purely illustrative scenario, the likelihood that this could disproportionately and inequitably disadvantage that patient from benefitting from their preferred pharmacy due principally to their medical condition

increases markedly, unless exemptions and safeguards are established. It is possible that certain rules could be set that would permit patients to use their preferred pharmacy after discharge from an in-patient stay where a prescription is dispensed initially from the on-site, in-network pharmacy, thus permitting such an arrangement yet not impeding a patient's right to choose their pharmacy. This may not fully address, however, other concerns such as fragmentation of care and the associated patient safety risks.

Ultimately much attention needs to be paid to understanding the various scenarios that may play out in order to identify the best possible model that benefits patients and the sustainability of our health system while equally addressing autonomy, continuity and access concerns. For some patients, continuity of care with a known pharmacy professional and access to their preferred local pharmacy may be of greater value than the care provided by a "Centre of Excellence". Thus, any consideration given to this approach should include the pharmacy regulator and ensure that the patient voice has been fully appreciated and considered.

Any Able and Willing Provider (AAWP)

6. Should insurers be required to demonstrate the reasonableness of terms in a PPN? If so, how?

Terms will most benefit patients if they are transparent, reasonable, and relevant in a way that permits the maximum number of patients to be able to maintain their autonomy and informed decision making, while enabling registrants to be able to consistently satisfy their professional and ethical obligations.

Having transparent terms provides pharmacies and the College with the information required to understand the obligations pharmacies are required to meet. To ensure the public is aware, terms should be readily accessible, and patients should be made aware of how and where to access them. The College understands terms currently might include pricing, services beyond dispensing, access to other services, or specified storage equipment, etc. However, any terms should be based on equity and the delivery of safe, ethical, and patient-centred care that has professional standards and the Code of Ethics as the underpinning principles in the delivery of safe and ethical pharmacy services.

A question that has not been asked in the consultation is *how* the terms in this model would be set. The College suggests that only organizations with a public protection or public interest mandate be involved in outlining the principles or method for setting these terms. The College's mandate and oversight of pharmacy makes us well positioned to contribute to the development of such principles, and/or the terms themselves, and ensuring that they would be transparent, patient-centred and auditable.

7. How should a pharmacy operator's ability to meet terms in a pharmacy PPN (e.g., terms relating to safety, quality of care, or value-added services) be determined and by whom?

The College is unclear what a reasonable scope for these terms would be when clear, objective evidence is not publicly available to show that terms of PPN models demonstrate better safety or quality of care or that "value-added" services are related to improved patient outcomes. However, we have established that the College can play a critical role in defining, setting and overseeing terms of such models so that they are relevant, reasonable, attainable and rooted principally in patient-centred care.

The College has several observations concerning "value-added" services. As opposed to terms related to patient safety and quality of care which can use existing practice, operational and ethical standards of the profession as a starting point, defining and determining the appropriateness of "value added" services as terms in such models is less clear and open to manipulation. As the Ministry considers the term and navigates claims that PPNs result in improve quality of care because of these services, the College notes that defining "value-added" will be important and that:

- The current use of the term "value-added services" implies an inherent value exists in the service provided. However, the College has not been able to identify evidence that this is a consistent claim that can be made across PPN models or that there is an accepted method for determining whether the quality or safety of care a patient receives within these models is due to these value-added services.

Further scrutiny is needed to understand the appropriateness, relevance and reasonableness of "value added services" in the context of the professional obligations to patients and our expectations as a regulator, and to fully protect against the use of such terms to justify exclusionary strategies by insurers and intermediaries.

- Patients have a right to person-centred care which means they also have a role in determining whether a value-added service is important or of value to them. This ought to be considered in how, and who, defines the terms of any such model.

- There are consent requirements, under the *Health Care Consent Act, 1996,* if the value-added service is considered a treatment and patients have the right to accept or refuse proposed treatments, further reinforcing the importance of how, and who defines, network terms.

The College would appreciate additional information from the Ministry to aid in ensuring that future recommendations from the College are evidence informed. Making such information also publicly available would promote greater public confidence in this process and the decisions made to protect their access to pharmacy care and affordable medicines.

8. How should disputes between insurers and pharmacy operators, and complaints by plan members or sponsors, be resolved?

As the regulator of pharmacy, the College expects that any concern about the practice or conduct of a registrant would come to our attention, either through a complaint filed by a patient, or a report submitted by another health professional or third party provider or organization. The College's existing authority to investigate complaints encompasses the behaviour of pharmacy professionals who are registrants of the College and who practice their profession within Ontario and/or operate a pharmacy within Ontario. It is our understanding that another regulatory body in Ontario retains authority to investigate complaints related to the administration of insurance products. Disputes solely between plan members or sponsors and insurers or their intermediaries are not currently within the scope of the College's authority.

However, this does not preclude the possibility of the College playing an expanded role, or taking on additional oversight, if it is in the public interest to do so and is relevant to the safe, quality and ethical delivery of pharmacy care. This suggestion has not been fully explored and, based on the mandates of OCP and other groups like the Financial Services Regulatory Authority (FSRA), there may be adequate mechanisms already in place to achieve this goal, provided that it is clear to all involved, including the public, what the roles and responsibilities are of our respective regulatory mandates.

As well, improved data related to concerns associated with such models should be made publicly available and done consistently regardless of what organization or entity has a role in addressing disputes or complaints involving any party involved. For example, the College annually reports on the number of complaints and reports it has received as well as an aggregated breakdown of the nature of the concerns reported to the College. This type of information would be important to monitor the implementation of any model so that progress and impact can be assessed and reported transparently, and opportunities to address them are identified expeditiously.

9. Should there be restrictions on the types of terms insurers may set for PPNs under AAWP? If so, what types of restrictions would be appropriate?

Any terms set under AAWP should be reasonable, relevant and transparent. Taking a principle-based approach to the types of terms that would be considered reasonable and relevant would promote greater public confidence in these models. Rather than terms set by insurers or intermediaries, the College can contribute to identifying the patient-centred and public interest principles needed to ensure that established terms do not create barriers for pharmacy professionals and pharmacists to meet their professional obligations and that address the patient care concerns that have been consistently raised to date.

In addition to playing a role in defining and setting terms and/or the principles upon which they are based, the College may also be able to play a key role in defining restrictions. These may be exceptions, under the SME or hybrid AAWP-SME model, or limitations to what the terms ought to be (or ought not to be), rooted in the public interest and in ensuring that they do not create unattainable conditions that a wider number of pharmacies would have difficulty meeting.

Standardized & Mandatory Exemptions (SME)

10. How should standardized exemptions be set, and by whom? (e.g., by one or more regulators, by an independent body, by statute or regulation enacted by the government)?

The Ministry provides examples of a person's age, ability and geographic location as criteria that could result in a mandatory exemption from a PPN. While these are patients who may be seen to benefit more from receiving continuity of care at a chosen pharmacy, this approach may not address the range of concerns regarding access to care that must consider, at a minimum, the *Human Rights Code, 1990* and the social determinants of health and may not adequately consider that a patient's health status is dynamic, not static.

Another considerations would be that the administrative processes required for patients to move into an exemption may be burdensome and difficult to understand. These unknowns suggest that exemptions based on strict patient characteristics, medical conditions or disease states carry the risk of conflicting with an individual's human rights.

Standardized exemptions could be set by an independent organization(s) motivated by the delivery of accessible, high-quality care to Ontarians with input from patient and community groups. The exemptions could also be set using a rigorous method that maximizes the number of individuals and communities with access to pharmacy care. The College, therefore, would be well positioned to play a key role in defining, setting and overseeing exemptions and can exercise its well-established consultation and regulatory oversight mechanisms to hear from patients, organizations, system partners, registrants and others to make sure that such exemptions are aligned within the College's mandate and that appropriately considers the input from those most affected by such decisions.

Once more information is available about the design and implementation of this model, the College would like to contribute to the Ministry's thinking to ensure patient-centred care is prioritized and to ensure clarity on how appropriate oversight is applied broadly to all parties involved, including pharmacies, insurers and intermediaries.

11. How should complaints relating to standardized exemptions be handled? Specifically:
    a. Who should be able to file complaints (e.g. plan members, pharmacy operators, prescribing physicians, plan sponsors)?
    b. Who should address such complaints (e.g. FSRA, OLHI, OCP, other entities)?

Anyone can file a complaint or report with the College about a pharmacy or regulated pharmacy professional. Based on our understanding of the SME model, if exemptions are based on patient characteristics, for example, then it may be that anyone who is advocating on behalf of the patient can file a complaint or a report. Depending on the nature of the complaint or report, more than one regulatory authority may need to play a more defined role subject to very clear rules that need to be established that delineate this responsibility appropriately and clearly (e.g. OCP must retain its oversight of pharmacy professionals and pharmacies). Data would also need to be shared openly and centrally so that all regulatory authorities, government, pharmacies, insurers and the public understand complaint and report trends which will strengthen the accountability of such models going forward. Oversight gaps, such as those related to the practices of intermediaries as they relate to the delivery of pharmacy services, necessitate further scrutiny.

With authority that is either strengthened or further clarified in regulation, standards or policy, the College may be able to be more involved in the oversight of such models in a way that gives the public confidence that patient-centred care is protected and that the authority for the College to be able to act is more firmly defined if the

government moves forward with either model or a hybrid of both. Ultimately, the concerns that are likely to be raised involving such models will involve pharmacy or pharmacy professionals as members of a patient's healthcare team, which makes OCP's involvement in identifying the best oversight solutions in any model critically important.

12. During the initial consultation, stakeholders indicated that certain exemptions are considered best practice for PPNs. Which types of exemptions should be instituted and for what reasons? Examples the government was made aware of during the initial consultation include:
    a. Exemptions for individuals with specific linguistic or cultural needs
    b. Exemptions for physicians to direct patients with complex needs to onsite pharmacy

The College recognizes that there are current practices that are not well understood by those outside of the insurance industry regarding exemptions which might be considered best practice. Regardless of such definitions put forward by insurers, the preferences of the patient are paramount, and the College expects that pharmacy professionals practice according to the principle of patient-centred care rooted in professional and ethical standards. These must underpin any definitions of best practice when referring to the delivery of safe, quality and ethical pharmacy care.

A Ministry of Health funded study, "*Barriers and Enablers to Primary Care Access for Equity-Deserving Populations in Ontario: A Scoping Review"* provides information on barriers to care that may also contribute to an understanding of populations who would benefit from exemptions. Further to the categorization of exemptions, it is important to establish a process for exemptions that is administratively simple and accessible for patients. The exemption should also be initiated quickly to prevent any patient from having to wait for their medication due to an administrative delay so as to avoid risks of harm to the patient.

While the first example of an exemption for those with specific cultural or linguistic needs appears to align with patient-centred principles, the second example raises questions about the appropriateness of a health professional directing patients to use a service without a clear patient-centred rationale. It may serve the public interest more effectively if exemptions were standardized in a way that maximizes patient autonomy and informed consent, equitable access and continuity of care. For this reason, the College's involvement in any solution could help to adequately protect the public interest and ensure alignment with the College's expectations of the profession including those who own and operate pharmacies.

Additional information from the Ministry that it can make publicly available, particularly as it relates to what other organizations determine to be best practices in PPNs, would strongly aid in making evidence-based decisions on a patient-centred approach to exemptions that considers the government's stated policy goals.

Targeted Questions

The following questions aim to gather feedback on concerns identified during the initial consultation which relate to specific categories of stakeholders.

13. *For Insurers, Pharmacy Operators, and Intermediaries:* What type of additional value-added services are pharmacy operators required to offer in order to dispense specialty medicine?

The College has chosen not to respond to this question because it is targeted to Insurers, Pharmacy Operator and Intermediaries, but would welcome involvement in future exploration of the types of "value-added" services a pharmacy may be required to offer as part of a PPN agreement and to have access to information the Ministry receives from these groups to help promote transparent and evidence-informed decision making.

14. *For Insurers, Pharmacy Operators, and Intermediaries:* What challenges could you face in implementing AAWP or SME?

The College has chosen not to respond to this question because it is targeted to Insurers, Pharmacy Operator and Intermediaries, but would welcome the opportunity to explore implementation challenges as it relates to the regulation of pharmacy and to have access to information the Ministry receives from these groups to help promote transparent and evidence-informed decision making.

15. *For Regulators, Insurers, Intermediaries, and Pharmacy Operators*: How should responsibility (e.g., oversight, enforcement) be allocated between provincial regulators under either option? Would the powers or mandate of one or both provincial regulators (i.e., OCP and FSRA) need to be revised?

Provincial legislation provides a comprehensive statutory framework that defines the scope of the College's authority, responsibilities, and accountability to the public and the Minister of Health. The College uses its powers under legislation and associated regulation to provide oversight and enforcement of registrants and pharmacies within our mandate. Our oversight includes entry to practice competencies and assessments, a quality assurance program and assessments, holding pharmacists and pharmacy technicians accountable to Standards of Practice and a Code of Ethics, and holding pharmacies accountable to the Standards of Operation. This oversight allows the College to revise our existing regulatory tools and programs to adapt to changes in pharmacy practice.

If the College recognizes there are public protection needs in areas where our authority does not reach, we will collaborate with other regulators and relevant organizations, including government, to identify gaps and explore options. Where gaps continue to exist, the College will explore other policy options as well as ways that our authority may need to expand to ensure all areas related to public safety in pharmacy care are addressed.

In addition to our authority to set standards, the College has the authority to investigate and respond to registrants and pharmacies not meeting their regulatory requirements. The College's professional misconduct regulations set out behaviour that may be considered professional misconduct including practicing while in a conflict of interest and failing to disclose conflicts of interest to patients. The provisions in our proprietary misconduct regulations make it clear that *entering into an agreement that restricts a person's choice of a pharmacy or pharmacist without the person's written consent* may be considered an act of proprietary misconduct. These provisions provide the College with the ability to discipline registrants as well as revoke certificates of accreditation for pharmacies that are found to have committed relevant acts of misconduct. This reinforces the importance of rooting any approach to how either model moves forward in the well-established expectations of the profession.

If there are areas under an AAWP or SME model that are not effectively addressed, the College may need to seek to extend its existing authority to ensure there are ways to address acts of professional or proprietary misconduct that may appear under the AAWP or SME models, or to continue to explore policy options within its existing authority to achieve its public-interest mandate effectively. With more information about the models and their implementation, the College will work with the Ministry of Finance, and the Ministry of Health, to determine if revisions to legislation or regulation is necessary in order to strengthen, and not diminish in any way, our regulatory oversight role of pharmacy in the province as either model moves forward.

16. *For Rural/Northern Ontarians:* Which, if any, of the proposed options would best improve their ability to access care?
17. *For Ontarians with Disabilities and for Ontarians Aged 55+:* Which, if any, of the proposed options would best alleviate the burdens (e.g., using specific pharmacies, delivery-only) on account of age or disability?
18. For Indigenous Communities and Linguistic or Cultural Minorities: Which, if any, of the proposed options would eliminate barriers that PPNs may pose in accessing culturally-appropriate care and/or care in a preferred language (including French, ASL, LSQ, Indigenous languages)?

There is a body of literature regarding access to care for Ontarians that the Ministry may use to inform its

consultation on the above targeted questions. For example, the "*RISE brief for citizens: Identifying how Ontario Health Teams can meet the needs of rurally based patient and community partners"* is a resource where the voices of rural Ontarians have been captured in response to gaps in health services.

The College continues to embed equity in our analyses and is aware that policy decisions affect different populations of people differently for a myriad of reasons. Looking at the potential impact on specific populations across Ontario is important, and exploring the nuanced ways that policy affects patients differently throughout this process will need to include organizations and groups of patients that can better capture their unique experiences. The College, which has established consultation and engagement mechanisms, can help facilitate discussions within the context of supporting decision making in the public interest.

Below are high-level observations as a regulator with provincial scope, but do not constitute a comprehensive analysis or broad engagement with patients who identify with these descriptors.

<u>Rural and Northern</u>
Any model seeking to address concerns related to Rural and Northern Ontarians must provide access to, and choice of, pharmacy care that meets the patient's values and preferences alongside their needs. The College has observed that currently, patients in Northern or rural areas with limited options for accessing pharmacy care must navigate decisions related to the mode that care is provided (i.e. virtual care vs. in-person, delivery of medications vs. in-person dispensed medications). This can exacerbate concerns related to patient-steering which is not in keeping with patient-centered care.

If understood correctly, rural and Northern individuals could be exempt from having to receive care from a network pharmacy. Consequently, the SME model appears most likely to enable patients living in rural or Northern communities to access pharmacy care in a manner that responds to their preferences and meets their needs. This would need to be further tested.

<u>Ontarians with Disabilities and Ontarians Aged 55+</u>
There are administrative processes involved in accessing insured services that the patient must navigate, and this can be particularly difficult for patients living with certain conditions or disabilities including those that affect cognitive processing and neurological functioning. The College has heard from several registrants who currently support their patients through the administrative process of accessing existing patient support programs and the administrative burden that exists for patients navigating insurance plan coverage who have expressed concerns that some patient populations may be disproportionately affected by delays associated with these processes. A model that is simple, with clear exemptions that do not require complicated approval processes, would be important to minimize the effect of these administrative requirements on patients.

<u>Indigenous Communities & Linguistic or Cultural Minorities</u>
The needs of patients who are Indigenous likely differ beyond cultural or linguistic differences, and the College advises that we are not in a position to provide a response about the needs patients who are Indigenous; therefore, direct engagement with Indigenous communities across Ontario will provide the Ministry with quality information to inform the analysis. The response above also applies to those who are linguistic minorities as the administrative process may pose challenges if English or French is not a language that the patient can navigate with confidence.

As noted, registrants already assist patients in navigating these processes and have observed that those with linguistic needs can need extra support in navigating existing processes. It is best to have a model that is simple, with minimal administrative burden placed on the patient and the pharmacy.

Conclusion

The public has come to know and trust in the care they receive at Ontario pharmacies, and this trust must be safeguarded as the government continues to work towards advancing a high-quality and sustainable provincial health system that promotes timely access to care closer to home for all Ontarians. This can be accomplished by exploring the College's role in how either model proposed by the government can move forward in a manner that satisfies the well-established patient care concerns associated with PPNs.

The College looks forward to ongoing collaboration and engagement with both the Ministry of Finance and Ministry of Health and to receiving additional information to ensure that decisions are evidence informed and are fully constructed on risk-based public interest principles that protect the fundamental value of patient-centered care.