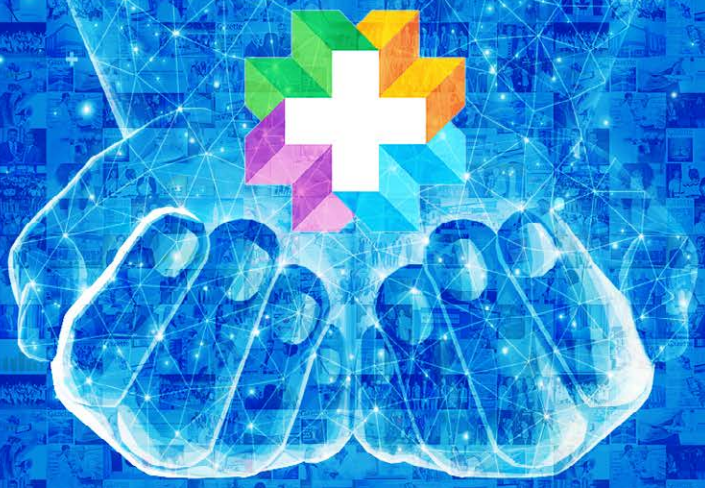
★ SPECIAL EDITION COVER STORY ★ By Karen Welds

30 years strong

Neighbourhood Pharmacies celebrates its anniversary by telling the story of the transformation of community pharmacy



We all know the aphorism, "Change is the only constant." While we also know it applies to just about everyone and everything, it would probably be fair to say that community pharmacy has seen more than its fair share of change in the past few decades. And for the most part, the good news outweighs the bad.

What better way for the Neighbourhood Pharmacy Association of Canada to recognize its 30th anniversary than to capture the kaleidoscope of pharmacy's evolution in this issue of *Neighbourhood Pharmacy Gazette* (which, by the way, recently celebrated its fifth full year of publication).

Change is rarely easy, and much important work remains ahead for both the business and the professional practice of community pharmacy. Yet as the following pages attest, the past bodes well for the future.

> "Community pharmacy is resilient. When given the chance, we will do wonders for the healthcare system."
>
> *—Chi Quon, General Manager, Pharmacies, Save-On-Foods*

Thank you to the following community pharmacists who walked down memory lane to help bring history to life—and who have themselves become change-makers in their respective organizations and as members of Neighbourhood Pharmacies.

Jim Johnston, Vice President and General Manager, National Pharmacy, Sobeys (a 1999 pharmacy graduate, University of Alberta)

Dimitris Polygenis, PharmD, President, McKesson Canada (1995, University of Toronto)

Chi Quon, General Manager, Pharmacies, Save-On-Foods (1989, University of British Columbia)

Rita Winn, Director, Lovell Drugs, part of the Neighbourly Pharmacy network (1981, University of Toronto)

★ SPECIAL EDITION COVER STORY ★

1995 – 2005

Dawn of a new era

"Pharmaceutical care" drove agendas for pharmacy regulators and advocacy bodies in the 1990s. Pharmaceutical care advocated that pharmacists' responsibilities go beyond dispensing and counselling on drugs at the time of dispensing to include monitoring patients' use of medications as well as their needs and expectations. In its 1992 submission to the provincial government, the College of Pharmacists of British Columbia spoke of the "enormous potential for community-based care."

Forty-nine per cent of surveyed pharmacy owners and managers reported having a counselling room or area in 1995, up from 17 per cent in 1994. That grew to 71 per cent in 1999.

By 1997, 13 per cent of pharmacies were billing for cognitive services, primarily in Quebec and B.C. where government funding was available for pharmaceutical opinions and trial prescriptions, respectively. By 2005, about one in five charged for expanded services.

In 2002, two-thirds of surveyed pharmacy owners and managers had at least one self-described specialist on staff, mainly for blood glucose meter training, diabetes management, medication management/compliance packaging, asthma and smoking cessation.

Moving out, moving in

Provincial pharmacy regulatory bodies began adopting a national drug schedule in the late 1990s. Several prescription and behind-the-counter medications moved into nonprescription aisles, including backache remedies, pain relievers, antihistamines, antacids and smoking cessation products. In 1997, surveyed pharmacists reported spending an average of 42 minutes daily counselling customers about nonprescription drugs.

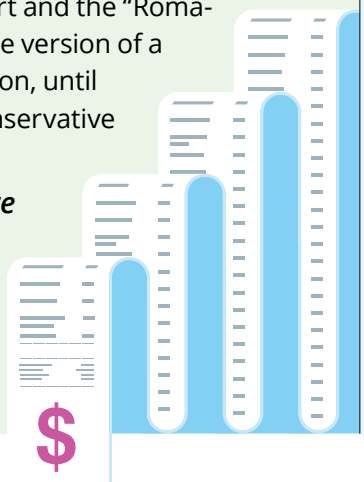
Back behind the counter, pharmacies began filling prescriptions for OxyContin, the first opioid for pain management, in 1996.

Déjà vu: pharmacare

In 1994, the Liberal federal government launched a four-year "national forum" on healthcare reform, including a closer look at systemic issues related to drugs in response to unprecedented growth in provincial spending. The Senate's "Kirby Committee" report and the "Romanow Commission" report followed in 2002. Some version of a national pharmacare was a recurring call to action, until it was shelved in 2006 with the election of a Conservative federal government.

"You don't hear anything about pharmacare any more these days, and you probably never will. That's because they understand how impossible it is to pay for it now."

—Michael Bliss, Professor of History of Medicine, University of Toronto, *National Post*, 2000



"I remember one doctor chewed me out because I intervened with a patient who was using their inhaler too often. Sure enough, they weren't using it properly. The patient told the doctor they now know how to use it, thanks to their pharmacist, and the doctor was so angry. Our role has certainly changed since then."

—Rita Winn, Director, Lovell Drugs

Business of better care

Against a backdrop of pharmaceutical care without remuneration, preferred provider organization (PPOs) and rising prescription-drug use, the Canadian Association of Chain Drug Stores (CACDS) was incorporated in 1995. It was the first national trade association representing the business of pharmacy—and charting pharmacy's value to governments, both economically and in healthcare. Its original 15 members represented corporately owned or franchise pharmacies.

From 1995 to 2000, CACDS's top issues were scanner pricing accuracy, supply-chain efficiencies, the regulation of natural health products and tobacco sales. In 1999, it spearheaded the Fredericton Pharmacy Initiative, one of the first to quantify the improved health outcomes and cost savings of pharmacists' interventions. CACDS co-chaired the Efficient Consumer Response for the Pharmacy Supply Chain (ECRx) working group to develop standards for bar coding and electronic data interchange.

From 2000 to 2005, the top issues included changes to drug scheduling, e-health and privacy legislation. Membership expanded to include banner pharmacies.

From the start, a core offering of the CACDS—and of Neighbourhood Pharmacies today—was intelligence-gathering and analytical support for provincial pharmacy associations during their discussions with governments.

Double-edged adjudication sword

Online adjudication took flight in the 1990s, delivering instant reimbursement from third-party drug plans—and new nightmares for pharmacy staff.

By 2000, pharmacists estimated they spent 53 minutes per eight-hour shift dealing with the one in 10 prescription claims rejected by private drug plans. Respondents described having to navigate multiple formularies, call centres and "screaming" patients. Insurers and pharmacy benefits managers (PBMs) established the Electronic Standards Council to establish standards for claims processing.

Butting in, butting out

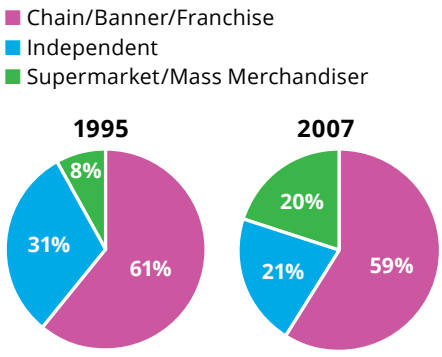
The Ontario government banned the sale of tobacco products in pharmacies in 1995, followed by Quebec in 1998. In 2002, up to a third of pharmacies in remaining provinces sold tobacco and the numbers were slowly declining. Meanwhile, smoking cessation products had become one of the fastest growing categories in pharmacies.

> **"I had a typewriter on the shelf to use when the computer wasn't working, and a lot of billing was still done with manual paper forms."**
>
> *—Jim Johnston, Vice President and General Manager, National Pharmacy, Sobeys*

TREND SNAPSHOT

Pharmacy formats

BREAKDOWN OF THE NUMBER OF PHARMACIES



Source: IQVIA Canada (formerly IMS Health)

PPOs before PPNs

In 1995, Foxmeyer claimed that almost half of Canada's pharmacies had signed on to its preferred provider organization (PPO). While the PBM went bankrupt the following year, most surveyed pharmacists agreed that PPOs were inevitable and about one in 10 were participating in at least one.

A 1997 survey revealed that the top services of pharmacies working with private payors (such as a local employer) were generic substitution (which was not yet mandated by provincial governments), 90-day supplies and patient call-backs. Seventeen per cent reduced their dispensing fee as part of their agreement with the private payor.

On a related note, MediTrust, Canada's first mail-order-only pharmacy, had established a national presence by 1995. It introduced the business model of a client base composed solely of employers with drug plans. In 1999, MediTrust was acquired by Pharma Plus Drug Marts, which in turn was acquired by Katz Group.

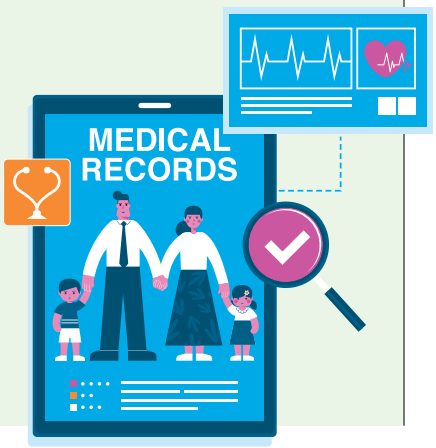
Wanted: pharmacists

From 2001 to 2009, about half of owners and managers reported a shortage of pharmacists in their own pharmacy.

The shortage helped propel pharmacists' wages. After a modest gain of nine per cent in the five-year period from 1995 ($26.60) to 2000 ($29.10), the average wage jumped 26 per cent over the next three years, reaching $36.70 in 2003, and another 16 per cent over the subsequent three years, reaching $42.75 in 2006.

EHR on the scene

Canada Health Infoway debuted in 2001 with a $1.1 billion budget from the federal government. It was tasked with accelerating the adoption of digital health technologies, including electronic health records, across provinces and territories.



Boomers and blockbusters

Prescription volumes began to soar in the 1990s, propelled by middle-aged baby boomers and blockbuster medications such as Lipitor for cholesterol.

The total number of prescriptions dispensed in Canada grew from 226 million in 1995 to 396 million in 2005, reported IMS Health. As an average per pharmacy, the prescription volume of 34,000 in 1995 almost doubled to 60,000 in 2006, according to surveyed owners and managers.

IMS Health reported a total of 6,527 community pharmacies in 1995 and 7,707 in 2005. That's an increase of 18 per cent against a growth rate of 75 per cent in total prescription volume.

Total prescription purchases in retail pharmacies more than doubled, from $6.4 billion in 1995 to $14.6 billion in 2005. Surveyed owners and managers reported that the dispensary's share of sales grew from 60 per cent to 72 per cent in that period. In 1995, 15 per cent of owners and managers reported a loss. By 2005, that had declined to two per cent.

> **"Back in 1995, advancing even just a few tablets was a risk. When somebody ran out of refills for their oral contraceptive, I was trained to punch out a few tablets and take a deposit because that prescription might not get okayed by the physician. It was a very different type of practice."**
>
> *—Chi Quon, General Manager, Pharmacies, Save-On-Foods*

★ SPECIAL EDITION COVER STORY ★

2005 – 2015

Governments gave with one hand …

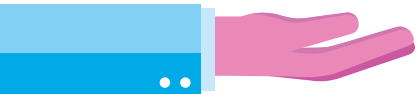
Expansions to scope of practice began in 2007, when Alberta enabled all pharmacists to adapt and renew prescriptions and prescribe in emergencies. It also announced pharmacists would be able to administer injections (with training) and apply for additional prescribing authority (APA). Pharmacists with APA would be able to prescribe any Schedule 1 drug or vaccine.

By 2015, pharmacists in all provinces could renew and adapt prescriptions (with some exclusions or restrictions for therapeutic substitutions) and all but those in Quebec could administer flu vaccines (and in some cases, other vaccines or drugs, depending on the province).

2007 also marked the start of pharmacist-led, publicly funded programs for medication reviews. Ontario's MedsCheck was the first, followed by similar programs in B.C., Alberta, New Brunswick, Nova Scotia and Newfoundland and Labrador. Alberta's medication reviews were part of two larger programs for care plans and medication management, for patients with chronic diseases or risk factors.

In 2011, pharmacists in Saskatchewan and Nova Scotia became the first (after pharmacists in Alberta with APA) to be able to assess and prescribe for a list of minor ailments. By 2015, all provinces except B.C. and Ontario could assess and prescribe for certain minor ailments.

… and took away with the other



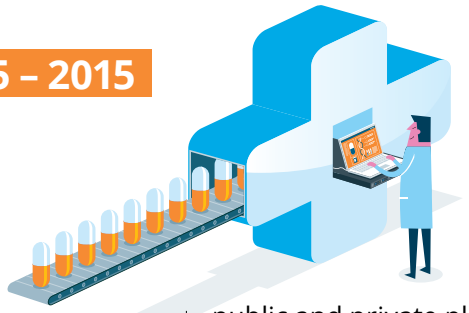
Provincial governments' reforms to public drug plans began in 2006 with Ontario's Transparent Drug System for Patients Act, which eliminated rebates paid by generic manufacturers to pharmacies (see "The generic effect," page 9). Surveyed owners and managers in Ontario reported an average direct loss of $60,400 in revenue. Then in 2010, the banning of professional allowances from manufacturers and the lowering of prices for generic drugs caused an average loss of $122,900 in revenue per pharmacy.

Other provinces—Quebec, B.C. and Alberta to start—followed with their own drug-plan policies that restricted commercial terms, lowered generic-drug prices, capped dispensing fees and capped markups. Across Canada, pharmacy revenue from markups significantly declined due to the lower prices of generic drugs. The impact on dispensary revenue was such that, in 2013, surveyed owners and managers reported the dispensary's share of total revenue was 58 per cent, down from 69 per cent in 2008.

"We joined CACDS in 98 or 99 for its resources—for example, when the new privacy laws came into effect. And at committee meetings and conferences you would get so much information, so many ideas and perspectives. When we sat at the same table, we all had the same problems and we worked together. It was such a strong network, and still is today."

—Rita Winn, Director, Lovell Drugs

The generic effect



The generic pharmaceutical industry in Canada grew rapidly in the 1970s and 80s, incentivized by government policy as a way to bring down drug prices. By the end of the 90s, generic manufacturers' commercial terms with pharmacies had become an important source of indirect funding for the growing number of pharmaceutical-care services in pharmacies, which received little or no direct funding from third-party payors.

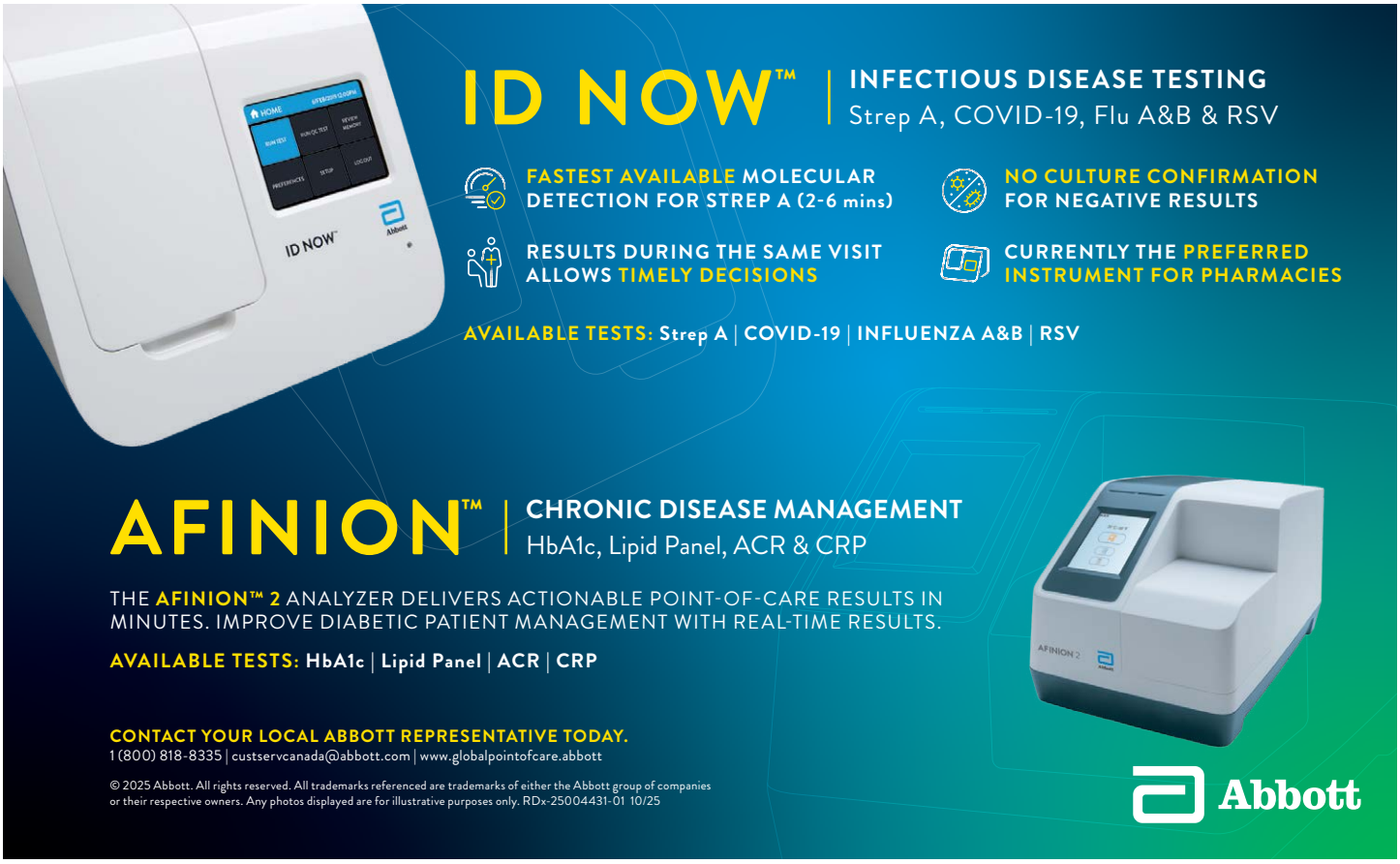
Generic volume surged in the early 2000s when several blockbuster brand-name drugs, such as Lipitor, lost patent exclusivity. While the shift to lower-cost generics saw overall sales growth plummet, from a record high of 17 per cent in 2001 to little or no growth from 2010 to 2015, generics steadily drove overall prescription volume and accounted for 68 per cent in 2015. Public and private payors reaped the savings from lower-cost generics and new mandatory substitution policies.

Starting in 2006, provinces restricted what could be included in generic manufacturers' commercial terms with pharmacies (including the eventual banning of professional allowances). One by one, provinces also began mandating lower prices for generics, for both public and private plans.

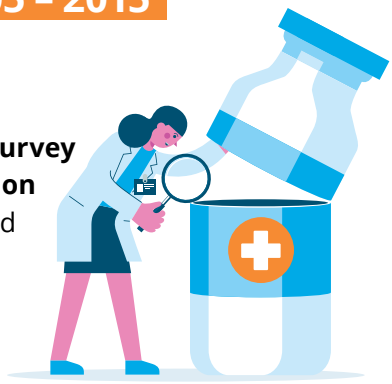
In 2010, most of the provinces (except Quebec) came together to create the pan-Canadian Pricing Alliance, which became the pan-Canadian Pharmaceutical Alliance (pCPA). In 2014, the pCPA implemented the Generic Tiered Pricing Framework, which harmonized generic pricing in all participating provinces and lowered the price of 10 high-volume generics to 18 per cent of the brand-name price. In 2015, that list grew to 18 drugs and Quebec joined the pCPA (see "Wrestling price compression," page 13, for more on the impact on pharmacy).

"The old pharmacy business model has been wiped out virtually overnight. There is no other sustainable model replacing it."

—Pharmacy owner responding to the 2014 Trends & Insights Survey of Community Pharmacists, Rogers Healthcare Group



Drug shortages



In the 2010 Canadian Drug Shortages Survey by the Canadian Pharmacists Association (CPhA), 89 per cent of pharmacists agreed that drug shortages—mainly of generic drugs—had greatly increased in the past 12 months. They spent an average of 30 minutes per shift dealing with them.

In 2011, surveyed owners and managers put drug shortages at the top of their list of challenges, ahead of provincial governments' changes to drug plans.

In 2012, drug shortages hit the national media when shortages of analgesics, anesthetics, antibiotics and other products caused surgeries to be delayed or even cancelled.

Fees? Yes and no

Only flu vaccinations were publicly funded across the board and from the start. Some provinces paid pharmacies for renewals, adaptations or substitutions (depending on the service), and fees themselves varied widely. Of the eight provinces with pharmacist-led programs for minor ailments in 2015, only three paid pharmacists for services rendered.

To help offset the revenue lost due to drug-plan reforms, some provincial governments increased their reimbursement of the dispensing fee. Ontario pharmacy owners and managers surveyed in 2011 estimated the higher fee of $8 recouped about $18,000 of the $123,000 in lost revenue.

The 2007 B.C. Activity Based Costing Study concluded that the filling of a prescription costs an average of $13.60 for dispensing services and administrative costs, versus the B.C. government's fee of $8.60 at the time. The 2008 Cost of Ontario Community Pharmacy Services (commissioned by CACDS and the Ontario Pharmacists Association) determined a median cost of $13.77 to dispense a medication.

In 2012, the Alberta Pharmacists' Association (RxA) successfully negotiated a separate funding framework for pharmacy services, the first in Canada. All expanded services could now be billed to the government. By the end of 2016, Alberta pharmacies submitted more than one million claims for care plans (including follow-ups).

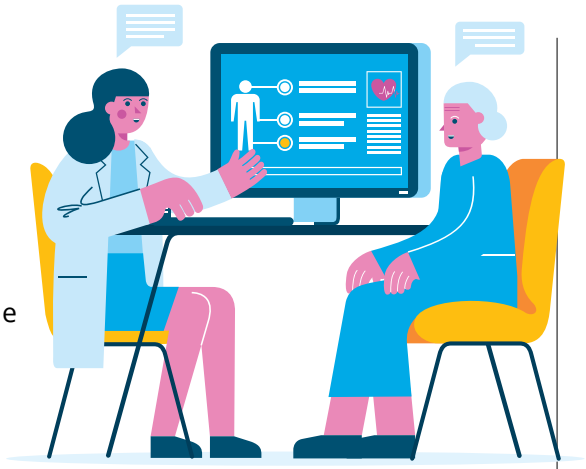
In 2013, the Pharmacy Association of Nova Scotia successfully negotiated government funding for demonstration research projects. The success of those projects—most of which became permanent programs—contributed to the development of that province's separate agreement for the funding of pharmacy services (in 2019).

Technicians come on board

Pharmacy regulatory bodies in Ontario, B.C. and Alberta were the first to register licenced pharmacy technicians in 2010 and 2011. By the end of 2015, pharmacy technicians were regulated professionals in all provinces except Manitoba and Quebec.

> **"We've always believed in Neighbourhood Pharmacies. It's the only entity that focuses on the business element and connects it to the professional side. That's very important. As members we may be competitors but there are many issues that we all believe in and can move forward on with a common agenda that benefits everyone, including governments."**
>
> *—Chi Quon, General Manager, Pharmacies, Save-On-Foods*

Services take root



By 2014, 64 per cent of surveyed pharmacists personally provided expanded services, up from 33 per cent in 2006. The top three services in 2006—diabetes care, medication management and smoking cessation—transitioned by 2014 to three services that were billable to public plans: medication reviews, immunizations and prescribing services (e.g., renewals).

In 2016, 37 per cent of owners and managers had at least one pharmacist with specialty designation on staff (e.g., Certified Diabetes Educator). Also in 2016, the Alberta College of Pharmacists reported that almost one in three pharmacists had additional prescribing authority.

In 2011, Ontario expanded its MedsCheck program to include MedsCheck for Diabetes, MedsCheck for Long-Term Care and MedsCheck at Home. In 2012, Ontario pharmacies conducted more than one million MedsChecks (including follow-ups).

In 2015, pharmacists in the nine provinces with injection authority administered just over two million flu shots, representing an average of seven per cent of the population in those provinces.

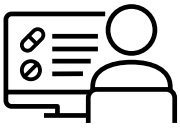
Here's what's special(ty)

In 2015, life-changing, higher-cost biologic and other specialty drugs began to reverse the deflationary impact of generics: after more than five years of little or no growth, the dollar value of the prescription drugs market was again on the rise.

The first biologic disease-modifying antirheumatic drugs were approved in 2000 and 2001; by 2011, biologics for rheumatoid arthritis alone pushed that category of drugs to the top of adjudicators' lists, where it stayed for more than a decade.

Status report: e-health

In 2008, P.E.I. became the first province to implement a real-time drug information system (DIS) that met the standards of Canada Health Infoway as part of the development of an electronic health record (EHR). Remaining provinces and territories rolled out their DIS by 2015.



92% **Pharmacists who reported improvements in the quality of patient care following the implementation of their province's drug information system**

Source: 2014 Survey of Pharmacists, Canada Health Infoway and Canadian Pharmacists Association

"I'm thankful and proud for the opportunity to be among the early pioneers of specialty health. We saw the introduction of amazing, life-saving, and breakthrough therapies that changed people's lives; but accessing these therapies was complicated starting from reimbursement and access, to cold chain logistics, and ultimately administration. Helping to develop solutions to those challenges and be part of a new model of healthcare was, and continues to be, extremely rewarding."

—Dimitris Polygenis, PharmD, President, McKesson Canada

Private plan matters

Private payors followed the lead of public payors and slowly introduced mandatory generic substitution policies to benefit from the lower prices of generic drugs under the pCPA's Generic Tiered Pricing Framework.

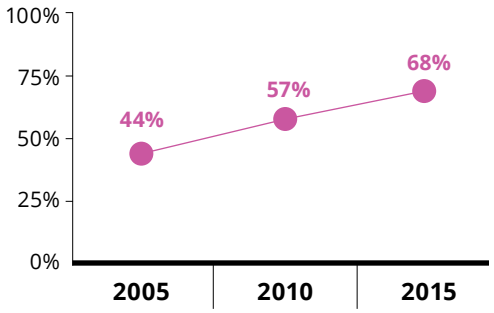
Rejected claims were still a thorn in the side—pharmacists surveyed in 2008 reported they took an average of 10 minutes per hour of work and four out of five agreed that drug-plan issues negatively affected patient care.

By 2015, PPOs had become preferred provider networks (PPNs) and 38 per cent of pharmacies were participating in at least one. The focus of private insurers had shifted to PPNs for high-cost specialty drugs.

TREND SNAPSHOT

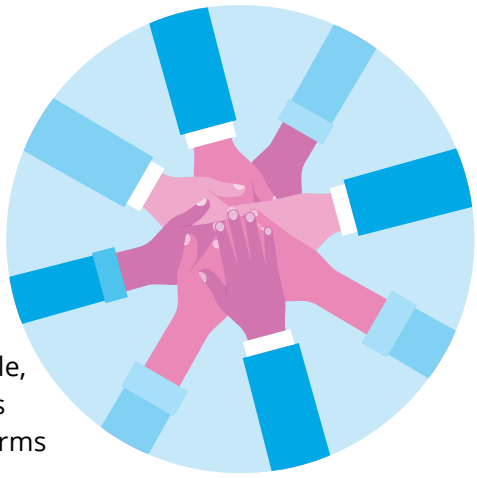
Generics

GENERIC DRUGS' SHARE OF PRESCRIPTION VOLUME



Source: IMS Health Canada (2005), IMS Brogan (2010), QuintilesIMS (2015)

What's up, CACDS ... er, Neighbourhood Pharmacies



In 2009 and 2010, CACDS conducted extensive research to determine the economic impacts of drug-plan reform on the average community pharmacy in each province. In Ontario, for example, CACDS projected a revenue loss of $200,000 resulting from reforms in 2010.

In 2009, CACDS released its Framework to Define and Fund Pharmacy Services as part of the Blueprint for Pharmacy initiative led by CPhA. Used in talks with the B.C., Alberta and Ontario governments, the framework helped lead to transitional funding as reforms were implemented (e.g., higher dispensing fees and/or the reinvestment of some of the savings into new pharmacy services).

In addition to provincial drug-plan reforms, top advocacy priorities included pharmacists' role in public health, the EHR and e-prescribing, and remuneration for pharmacy services.

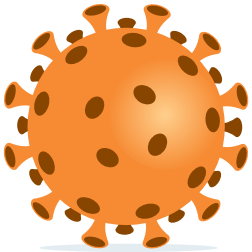
In 2014, CACDS changed its name to the Neighbourhood Pharmacy Association of Canada (Neighbourhood Pharmacies) to accurately reflect the breadth of pharmacy formats represented by its members—including, by this time, independent and banner networks and specialty pharmacies.

> **"We are not corporate or independent or specialty pharmacy—we are pharmacy. And we are committed to patient choice above all. That is the crux of person-centred care. To protect the future of pharmacy, we will collaborate and coordinate on behalf of our patients, no matter how complex—or seemingly simple—the drug or the care."**
>
> *—Sandra Hanna, CEO, Neighbourhood Pharmacies*

★ SPECIAL EDITION COVER STORY ★

2015 – 2025…AND BEYOND

The turning point



The COVID-19 pandemic stopped the world in March 2020—and galvanized community pharmacy in Canada. As family physicians and other healthcare providers scrambled to establish new channels for communications and access to care, Canadians flocked to pharmacies for answers. And, of course and always, for needed medications.

Governments also turned to pharmacies for solutions. Neighbourhood Pharmacies, with other national and provincial stakeholders in pharmacy and across the supply chain, worked around the clock with Health Canada and provincial governments to stabilize drug supply and mobilize an infrastructure of more than 11,000 community pharmacies from coast to coast to coast. Scopes were expanded, regulations revised and fees for new services put in place in a matter of weeks.

Pharmacies demonstrated their ability to pivot and deploy in ways that public health units, physicians' offices and emergency departments could not, be it for public education, online appointment bookings, virtual consultations, the distribution of testing kits, point-of-care testing, vaccinations—more than 21 million by the end of 2022—or assessing and prescribing treatment for mild to moderate cases of COVID-19.

"We eliminated the competitive piece and were able to capitalize on the structure of a pharmacy, its operating hours and its team approach. It was really important for governments to see that we could do that."

—Alison Bodnar, CEO of the Pharmacy Association of Nova Scotia, *Neighbourhood Pharmacy Gazette*, Fall-Winter 2021

Wrestling price compression

In 2016, the PMPRB announced it would reform how it set price ceilings for patented medicines—with a stated goal to save $8.8 billion over 10 years. Almost 10 years would pass before its changes finally take full effect (on January 1, 2026).

Opposition from all sectors of the drug supply chain and patient groups—speaking to the downstream repercussions on access to medications—resulted in several rounds of consultation. Neighbourhood Pharmacies emphasized the unintended consequences on patient care since pharmacy services are primarily funded by markups tied to drug prices.

Pharmaceutical manufacturers also launched legal challenges. Provincial and federal courts eventually ruled against the most contested reforms, stating the PMPRB had overstepped. PMPRB's stripped-down new framework will remove an estimated $1.3 billion annually due to lower drug prices.

The pandemic also played a part in changing PMPRB's course by demonstrating the importance of domestic pharmaceutical manufacturing, the complexity and fragility of the drug supply chain, and the connections between pricing, funding models for pharmacy and distributors, and access to new medications.

On the generic front, the Generic Tiered Pricing Framework's five-year renewal in 2018 further discounted the prices of the highest-volume generics to 90 per cent of the brand price. Its three-year renewal in 2023 instigated earlier automatic price drops for new generics.

Since 2007, generic prices overall have dropped by about 70 per cent. The downstream impacts include a significant increase in drug shortages (see "Shortages persist," page 17) and, since the first Generic Tiered Pricing Framework in 2014, a loss of more than $2 billion in pharmacy revenue, according to an internal analysis prepared by Neighbourhood Pharmacies for its members.

"The real issues around funding in pharmacy revolve around the uncertainties faced by pharmacy operators as they try to scale up their services in primary care and public health. More than ever, we are advocating a whole-of-government approach that considers the impacts of policy throughout the drug supply chain."

—Sandra Hanna, CEO, Neighbourhood Pharmacies

Pharmacare is back, sort of

Talks of a national pharmacare resumed in 2015 under the new Liberal federal government led by Prime Minister Justin Trudeau. Nine years later, the Pharmacare Act became law and universal, single-payor, first-dollar coverage became available—pending the signing of bilateral agreements with provinces and territories—for selected diabetes drugs and devices and contraceptives.

Once in place in all jurisdictions, Neighbourhood Pharmacies predicted a loss of $43 million annually in community pharmacies due to the lower dispensing fees (many of which haven't increased in more than a decade) and markups of public payors.

In 2025, Manitoba and P.E.I. implemented national pharmacare for the two categories of drugs. Yukon is scheduled to do so in January 2026, followed by B.C. in April 2026. While the new Liberal Prime Minister Mark Carney confirmed a commitment to bilateral agreements with remaining jurisdictions, no talks are currently underway. Nor did the federal government set aside additional funding in its latest budget.

Leveraging its pan-Canadian lens, Neighbourhood Pharmacies is sharing the experiences of pharmacies in Manitoba and P.E.I. with other provincial and territorial governments to help shape their rollouts of national pharmacare.

"This is an opportunity for renewed discussions. In today's Trump-era economic environment, Prime Minister Carney's commitment to Pharmacare could look very different than that of the previous government."

—Sandra Hanna, CEO, Neighbourhood Pharmacies

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LET'S INVEST
IN CANADA.

YOUR TRUSTED PARTNER IN CANADIAN HEALTHCARE

Supporting Canadian manufacturers strengthens our economy and ensures a healthy future for all.

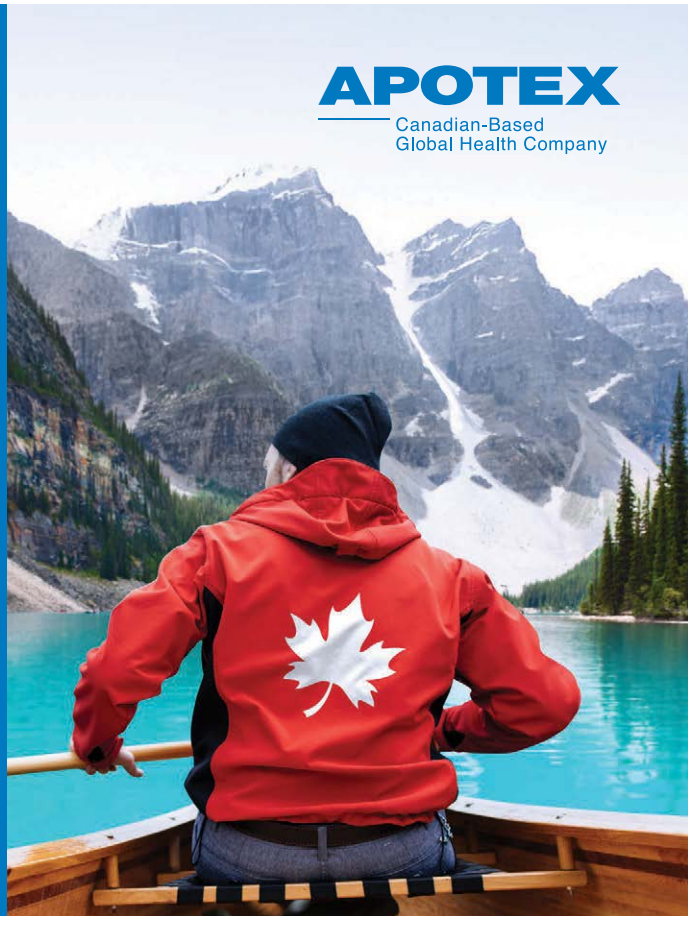
345+ Generic products*

70+ Branded pharmaceuticals*

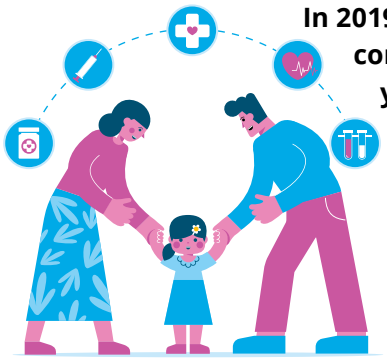
4 Biosimilar products*

*Apotex data on file. Represents the total number of products offered in the Canadian market.

APOTEX
Canadian-Based Global Health Company



Drugs for rare diseases



In 2019, the federal government committed $1.5 billion over three years to a national strategy for drugs for rare diseases. By March 2025, it had signed bilateral agreements with provinces and territories. Twelve of the 13 jurisdictions used the federal funds to cover one or more of the 12 drugs on a common list of ultra-high-cost drugs for rare diseases. Quebec used the funds to support its own action plan.

Neighbourhood Pharmacies is a member of the strategy's Implementation Advisory Group.

Services go up, up, up

Expanded services in pharmacies have grown steadily in the last decade, for several reasons: pharmacists' increased confidence, the public's increased acceptance and expectations, continued expansions to scope and more public funding. Some provinces also removed restrictions (e.g., making funding universal rather than limited to public-plan beneficiaries).

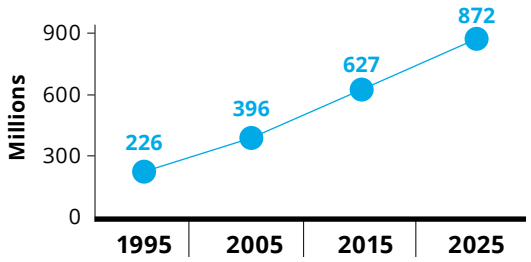
Some bumps occurred along the way—the pandemic most of all. And some provinces lag to this day in significant areas—namely in Ontario and Manitoba, where scopes still exclude therapeutic substitution, and prescription renewals and adaptations are not funded. But overall, pharmacy services grew (see "A sampling of growth in services," page 18).

Nova Scotia broke a new frontier when, in September 2024, the government announced permanent funding for 46 Community Pharmacy Primary Care Clinics (CPPCCs) after an 18-month pilot project. The clinics focus exclusively on appointment-based services, use an electronic medical record and collaborate virtually with dedicated nurse practitioners.

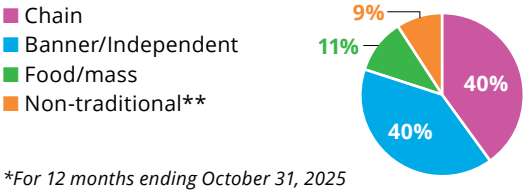
In Quebec, regulations are underway for the adoption of a new scope of practice that has removed previous restrictions and essentially gives pharmacists full autonomy, including for assessments and prescribing of any Schedule 1 drug.

A whole lotta medications

PRESCRIPTIONS DISPENSED BY COMMUNITY PHARMACIES, 1995 - 2025



BREAKDOWN BY FORMAT, 2025*



**For 12 months ending October 31, 2025*
***Non-traditional includes specialty, long-term care, mail-order and hospital out-patient pharmacies*
Source: IQVIA Canada (formerly QuintilesIMS [2015] and IMS Health [1995, 2005]

"I'm optimistic about pharmacy and our ability to provide even greater value to the healthcare of Canadians. The medication and therapy landscape is changing, with many more specialized treatments. Some continue to talk about specialty pharmacy as a separate thing but to me, pharmacy is pharmacy, and the profession is rising to the occasion. Pharmacists should have the opportunity to support all of a patient's pharmaceutical needs and we're here to support them to do that."

—Dimitris Polygenis, PharmD, President, McKesson Canada

The funding tug-of-war

Shortly after the government in Nova Scotia confirmed funding for pharmacy-led primary care clinics, the Alberta government dropped fees for care plans to $70 from $100 and limited billable follow-ups to four from 12. It was the second cut in the decade: in early 2018, it removed the higher fee of $125 per care plan for pharmacists with APA.

In June 2025, Alberta discontinued funding COVID vaccinations in pharmacy. The Alberta Pharmacists' Association estimated the two cutbacks will result in an annual loss of $38 million for pharmacies.

In other provinces, the pattern appears to be one of two-steps-forward-one-step-back for the funding of services, be it for prescribing, vaccinations or point-of-care testing.

As of January 2026, the B.C. government will reimburse a dispensing fee of $11, up from $10, the first increase in 15 years. Dispensing fees in five other provinces have not increased in more than a decade. None are indexed to inflation.

Watershed moments could be coming in Nova Scotia and Quebec. Negotiations to renew agreements for fees for dispensing and expanded services have been underway for more than a year in both provinces. Nova Scotia is also negotiating the ongoing funding of services in the pharmacy-led primary care clinics. And in Quebec, once the current agreements are renewed, talks are set to resume on a new tiered remuneration model for dispensing that will be based on the complexity of services for the medication.

The specialty situation

By 2025, specialty medications accounted for 50 per cent of prescription dollars and two per cent of volume, reported IQVIA Canada. Specialty pharmacies, dedicated to patients taking specialty drugs, accounted for close to a third of the volume.

Neighbourhood Pharmacies' 2023 report with IQVIA, The Value of Specialty Pharmacy Services to the Healthcare System, estimated that pharmacy-led specialty-drug services invest and offset $1 billion annually for patients who would otherwise be unsupported by the public healthcare system.

Over the past decade, payors have steadily tiered or capped the markups on higher-cost drugs. Some caps from public payors are so low they essentially contribute nothing to cost recovery. Lower-cost biosimilars have further reduced markup revenue, even though they require the same patient-support services as the originator biologic.

Wherefore cannabis

Health Canada's consultation on proposed amendments to the Cannabis Act, including a new regulatory pathway for natural health products containing cannabidiol (NHPCCs), concluded in July 2025. In its submission, Neighbourhood Pharmacies recommended further amendments: that NHPCCs become exclusively available through community pharmacies and that community pharmacy's role in the provision of medical cannabis be expanded.

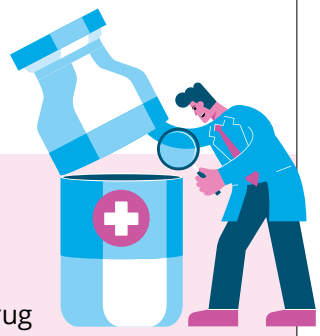
> **"It's hard not to get caught up in the challenges. But when we take a bird's-eye view, we can see that pharmacy teams are leaning into their training and practicing to their full scope. Pharmacy is reaching its potential to serve communities as healthcare destinations."**
>
> *—Sandra Hanna, CEO, Neighbourhood Pharmacies*

A central piece

All major pharmacy operators in Canada today have built at least one central-fill facility. But pharmacy regulations in almost all provinces and territories prevent central fill from realizing its full potential in a country where the population is spread across a large geographical area. Only Nova Scotia, New Brunswick and Newfoundland and Labrador allow cross-border central fill. In 2024, Alberta and Saskatchewan rescinded its policy enabling cross-border central fill after the regulatory bodies determined that legislative changes were required.

"Removing or modernizing regulations is a big part of the Carney government's push for a stronger national economy. The same reasoning needs to be applied to central fill to create a stronger healthcare system."

—Sandra Hanna, CEO, Neighbourhood Pharmacies



Shortages persist

A 2020 survey by CPhA found that pharmacists spent almost a quarter of their shift dealing with drug shortages. A 2021 survey of members of the Canadian Generic Pharmaceutical Association found that the number of domestically manufactured products declined by 34 per cent over the past three years. Less than half of generic drugs are manufactured domestically.

Health Canada's Drug Shortages Canada website reports 1,500 to 2,000 active shortages at any given time. Of note this year, a shortage of pain medications containing oxycodone began in July and may not be resolved until early next year.

For patients, the situation is worsened in some provinces by scopes of practice that limit pharmacists' ability to make therapeutic substitutions. Ontario and Manitoba do not permit therapeutic substitutions by pharmacists at all.

Workforce woes

The demand for pharmacists exceeds supply: a recent analysis by the Government of Canada concluded the profession "is expected to face a strong risk of labour shortage over the period of 2024-2033 at the national level."

Even well before the pandemic, levels of self-reported burnout were disconcertingly high among pharmacists. In 2024, pharmacy regulatory bodies in British Columbia, Ontario, New Brunswick and Nova Scotia announced strategies to address workplace conditions. Among national and provincial advocacy associations, including Neighbourhood Pharmacies, priority actions include streamlined pathways to licence international pharmacy graduates and enable Canadian pharmacists to practice in multiple provinces.

"Solutions must go beyond staffing levels. Fair remuneration for services is key, as well as regulatory change to maximize agility and efficiency in the business of pharmacy."

—Sandra Hanna, CEO, Neighbourhood Pharmacies

"We're going to continue to see governments recognize what pharmacists can do. More Canadians are recognizing what pharmacists can do. As those two groups catch up with the scope that pharmacists have been trained for, we will really see the clinical evolution of pharmacy. And the distribution piece will be more automated and efficient. Pharmacy might look very different than it does today."

—Jim Johnston, Vice President and General Manager, National Pharmacy, Sobeys

E-health update

With start-up funding from Health Canada, in 2017 Canada Health Infoway launched PrescribeIT, an e-prescribing platform for pharmacists and prescribers. Momentum appeared to build quickly as provincial and territorial governments entered into agreements with Infoway.

On January 1, 2025, pharmacies began paying a transaction fee of $0.20 per electronic prescription. Physicians and other prescribers do not pay a fee.

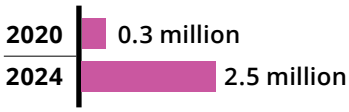
In related news, in 2023 the federal government budgeted another $25 billion to help provinces and territories complete their respective plans for the electronic exchange of health information between health professionals and with patients.

"E-prescribing is a critical tool to enable pharmacy and the health system of the future. We are far behind other countries. But we need a fair and sustainable funding model to get there. Governments have an important role to play, both in funding and championing adoption."

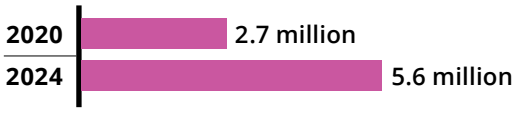
—Sandra Hanna, CEO, Neighbourhood Pharmacies

A sampling of growth in services

MINOR AILMENTS



PRESCRIPTION RENEWALS



5 million +
Flu shots administered annually since the pandemic

18 million
COVID-19 vaccines administered during the mass vaccination campaign in 2021-2022 (averaging 5 million annually since then)

Source: CFP Services Chart. The Canadian Foundation for Pharmacy.

PBMs in the hot seat?

In April 2025, the Competition Bureau of Canada launched an investigation of Express Scripts Canada, one of Canada's largest PBMs.

Media reports and complaints from the public and pharmacy operators also led Ontario's Ministry of Finance to hold two consultations, in 2024 and 2025, on the role of preferred provider networks (PPNs) in private drug plans. The PPNs may include online pharmacies owned by PBMs, and some PPNs (mainly those for high-cost specialty drugs) are closed (i.e., patients must use the PPN pharmacy to get coverage from their plan).

In November 2025, Ontario introduced Bill 68 to add "Any Willing Provider" legislation to the Insurance Act so that any pharmacy willing to match a PPN's financial terms can join. As well, it calls for a standardized, transparent process for patients to be able to opt out of PPNs and still receive coverage.

"What we've come to truly understand in the past decade is that more and more of our issues are joint issues. They affect both pharmacists as professionals and pharmacies as businesses. They involve both federal and provincial governments. They cross provincial borders. They demand collaboration across the supply chain."

—Sandra Hanna, CEO, Neighbourhood Pharmacies

Onward, Neighbourhood Pharmacies

Neighbourhood Pharmacies' 2025 public polling showed that Canadians are happy with the services in public health and primary care received in pharmacies—and they want to see more.

In 2024, Neighbourhood Pharmacies joined the World Pharmacy Council. On the home front, Neighbourhood Pharmacies' new governance structure enables more effective, collective advocacy on behalf of the three main business models of pharmacy (corporate retail, independent/banner and specialty). A new committee structure includes seats at the table for Partners (manufacturers and suppliers) to inform advocacy across the drug supply chain and help proactively prepare for advances in healthcare and technology.

As captured in its 2025 – 2029 strategic plan *Prescription for Success*, Neighbourhood Pharmacies' overarching vision is the integration of innovative pharmacy business models into the healthcare system. Its objectives include improving the long-term economic viability of pharmacy—and the healthcare system—through modernized, equitable funding and streamlined operations. Getting there requires rigorous data collection, the removal of administrative burdens in pharmacies, updated regulations and a structured, pan-Canadian approach to healthcare delivery and interprofessional consensus-building.

"Thriving businesses have the resources to invest in innovation and additional service delivery. A thriving pharmacy sector can bring more solutions to governments—and scale those solutions reliably and for maximum impact."

—Sandra Hanna, CEO, Neighbourhood Pharmacies

Neighbourhood Pharmacies today

21
Pharmacy Members

63
Premium and Associate Partners

30
Annual EXPO events featuring one-on-one exchanges between Members and Partners

6
Annual Specialty Pharmacy Summits, the only event of its kind in Canada

1
The only pan-Canadian pharmacy association working at both federal and provincial levels

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