



College of Pharmacy  
Department of Pharmacy  
Practice & Science  
789 S. Limestone  
Lexington, KY 40536-0082

859 323-7148  
fax 859 323-0069

**May 15, 2014**

Federal Trade Commission  
Office of The Secretary  
Room H-113 (Annex X)  
600 Pennsylvania Avenue NW  
Washington, DC 20580

**Re: Health Care Workshop Project No. P131207**

It is my pleasure to submit comments to the Federal Trade Commission (FTC) notice and questions regarding “Examining Health Care Competition.” 79 Fed. Reg. 10153 (2014). The comments are submitted to the FTC as it seeks to better understand the dynamics in the primary care and prescribing marketplaces and the expanding professional role pharmacists are serving to increase access, enhance patient satisfaction, increase quality, improve outcomes and reduce health care expenditures.

It has been my honor to serve in pharmacy education for 40 years, including 10 years in professional association management and a number of leadership roles while also conducting practice based research and teaching professional students. It is from this background and experience that I prepare and submit this statement.

When this country was founded health services were adopted from the English and European models where physicians and apothecaries or chemists collaborated providing patient care and compounded medicinal agents. Over the decades training for both providers became more formalized in the United States while the patient care procedures and medicinals became more complex and abundant. It was a common practice for citizens to address their health complaints initially to the apothecary (later known as the pharmacist) because of easy access and convenience. Pharmacists served in a primary care provider role in neighborhoods and communities all over the country and were essential care givers in locations without physicians. Such roles and relationships as these continued for the most part until after World War II.

The Durham-Humphrey Amendment to the Federal Food and Drug Act, enacted in 1946, restricted access to prescription medications and authorized licensed prescribers, primarily physicians and dentists. Subsequently for almost thirty years following the Amendment, pharmacists reverted to the role of abiding to physicians' orders and dispensing prescriptions. In the meantime pharmacy education and training moved ahead and evolved from a product focused curriculum preoccupied with accuracy, efficacy and safety to the adoption of a broader focus on patient care. Over the past 15 years all pharmacy graduates have been Doctor of Pharmacy prepared, as clinical pharmacists with medication therapy management expertise. No other health professional receives such broad, in depth education and clinical training in pharmacotherapy and medication therapy management as late 20<sup>th</sup> century and 21<sup>st</sup> century pharmacy graduates. Today there are approximately 150,000 Doctor of Pharmacy (PharmD) graduates practicing in this country. This highly skilled, underutilized professional workforce is eager to step forward to better serve the needs of their patients and to function at the highest levels of their professional competency. Lacking, however, is system-wide recognition of pharmacists as "providers."

Today, the distribution of physicians has become less widespread depriving convenient access to primary care and medications, primarily in rural and inner city regions. Moreover, the United States Government has enacted programs in the past 10 years that offer medication benefits to the elderly, Medicare Part D as well as health care coverage, the Affordable Care Act (ACA), for almost 40,000,000 uninsured citizens. The ACA requires insurance policies to provide "essential benefits including: *prescription drugs* and *chronic disease management*. These recent government acts have made available greater economic access to the elderly as well as uninsured or underinsured citizens while the availability of physicians to these groups of citizens has continued to decline. It has been estimated that at least 95,000 additional physicians would be required to provide services under the new health care benefits. This underserved and growing need has presented an opportunity for non-medical health professionals to present the case for expanded scope of practice authority. Pharmacy and other non-physician professions have proposed to expand scopes of practice with legislative initiatives to state governments as well as federal agencies that authorize and/or govern provider status. Pharmacists are seeking provider status with prescriber authority or to expand the scope of prescriber authority.

The rationale for pharmacists to pursue expanded scope of practice includes:

1. Increased demand created by 40,000,000 citizens with health care benefits including coverage for prescription medications.
2. The logic to utilize the capacity and expertise of the pharmacy workforce to improve access to primary care and appropriate use of prescription medications.
3. The documented benefits and professional competence of pharmacists as prescribers and medication therapy managers.

4. The documented availability of pharmacists to citizens in underserved areas.
5. The professional aspirations of pharmacists to collaborate on health teams.
6. The desire for well-educated and clinically trained pharmacists to practice at their levels of professional competence.
7. The highly unlikely circumstance that adequate numbers of physicians will be trained in time to serve the demand created by the Affordable Care Act.

Currently pharmacists have been granted primary care and prescribing authority to various degrees from Australia to Canada to the United Kingdom as well as in the Veterans Administration Health System and the United States Public Health Service. Pharmacists have practiced as primary care providers in the VA and the USPHS for more than thirty years. The quality, efficiency and effectiveness of care provided by VA and USPHS pharmacists in these systems are well documented.

Historically, in the United Kingdom, parts of Europe as well as the Far East, tradespersons called chemists and druggists perform prescribing. Having traveled to these countries, served a sabbatical in 2012 studying the expanded scope of pharmacy practice in Alberta, Canada as well as in Scotland and England, lecturing at their universities and studying their professional curriculums; I must state that pharmacy education in this country is more comprehensive and thorough in preparing graduates to be providers of patient care with a specialty in pharmacotherapy. Therefore the progression today toward prescribing by pharmacists is viewed as a return of the profession to historical beginnings. Presently, approximately 95% of the states in the US have enacted collaborative practice agreements. Numerous legislative bills have been addressed in 2014 to further expand the scope of practice for pharmacists. National professional organizations, led by the American Pharmacists Association, the American Society of Health System Pharmacists, the National Association of Chain Drug Stores and the National Community Pharmacists Association have enthusiastically endorsed and are pursuing the establishment of pharmacist provider status by federal government agencies responsible for health benefit programs.

In conclusion, this recognition is long overdue. Patients, who have access to pharmacists as providers and the health systems that make such services available, benefit in more effective care, reduced medication errors, increased medication adherence and improved patient satisfaction. It is past time to recognize pharmacists for their clinical skills and their patient care competence.

Respectfully,

Kenneth B. Roberts, BScPharm, MBA, PhD  
Slone Professor of Community Pharmacy Leadership and Dean Emeritus