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# PHARMACARE AND ACCESS TO MEDICINES IN CANADA;

# A POLICY BRIEF

Submission to Canadian Senate Standing Committee on Social Affairs, Science and Technology

September 13 2024

# Policy Brief on Pharmacare and Access to Medicines in Canada

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**Abstract**

Prescription drug provision is a fundamental component of health care systems across OECD countries, with almost all featuring universal coverage. However, Canada is a notable exception. Unlike other nations with universal health care, Canada lacks a cohesive pharmacare program, relying instead on a fragmented array of drug plans designed to assist those without access to private coverage. This patchwork system leaves many Canadians struggling to obtain the prescription medications they need.

This policy brief argues that the core issue with Canadian Pharmacare lies in its fragmented nature. The existing system is inequitable, inefficient, and unsustainable due to its lack of coherence and unified purpose. While some propose adding more layers to this patchwork, the policy brief asserts that the fundamental problem is its inherent fragmentation. This policy brief is divided in three sections:

1-An outline of the current state of drug coverage in Canada, highlighting issues related to access and costs,

2-A review of arguments in the ongoing debates surrounding drug coverage reform,

3-An analysis of recent federal legislation *Bill C-64; An Act respecting Pharmacare* aimed at laying the groundwork for universal pharmacare, including specific suggestions for necessary amendments to *Bill C-64; An Act respecting Pharmacare*.

# Policy Brief on Pharmacare and Access to Medicines in Canada

## Introduction

The provision of prescription drugs is typically a fundamental component of national health care systems, often viewed as an essential health service. Notably, every OECD country with universal health care covers prescription drugs, except Canada (ACINP 2019, 29). The concept of "Pharmacare" — public drug coverage distinct from universal health coverage (Medicare) — is a Canadian specificity. Although provinces offer some level of public drug coverage for non-working populations such as seniors and those on social assistance, the majority of Canadians receive drug coverage through private benefits provided by employers. Consequently, access to medicines is still conceived of in terms of privileges offered by employers to employees.

Pharmacare in Canada is characterized by a fragmented system comprising numerous drug plans designed to aid individuals without access to private insurance. This fragmentation results in many Canadians falling through the gaps and struggling to access necessary medications. Since 2015, the debate around reforming public drug coverage has intensified, and significant reforms are gradually being implemented (Adams and Smith 2017; Boothe 2018; Flood, Thomas, and Moten 2018; Marc-André Gagnon 2021). This policy brief outlines the current structure of drug coverage in Canada, evaluates its outcomes regarding access and costs, explores the ongoing debates and recent federal legislation aimed at introducing universal pharmacare, and, more specifically, explains why amendments are required to *Bill C-64; An Act Respecting Pharmacare*.

## 1. The Structure of Drug Coverage in Canada

Universal healthcare in Canada was first introduced in Saskatchewan by Premier Tommy Douglas in 1947 and, following the recommendations of the Royal Commission on Health Services (commonly referred to as the "Hall Commission") in 1964 (Canada Royal Commission on Health Services 1964), it was extended to the rest of Canada in the early 1970s based on a financial arrangement between the federal government and the provinces: the federal government provides financial transfers to the provinces if they offer universal healthcare coverage that respects specified standards defined in federal legislation. In 1984, the Canada Health Act (CHA) established the current set of standards, requiring that health insurance be universal, publicly administered, portable across provinces, comprehensive and accessible without direct charges to patients (Marchildon 2021). However, the CHA does not cover all medically necessary health care services; it is limited to coverage of medically necessary hospital and physician services only (Fierlbeck 2011, 89). While medicines used in hospitals are 100% publicly financed in accordance

with the CHA, there are no standards for the coverage of prescription drugs outside health care establishments.

As a consequence, access to prescription drugs in Canada relies on a confusing patchwork of over 100 public drug plans and over 100,000 private plans (ACINP 2019, 29). Each plan, public or private, has a variety of premiums, co-pays, deductibles or annual limits, creating critical discrepancies in the way a Canadian citizen may be covered, depending on where they live or where they work. The objectives of drug plans also vary: while public drug plans aim at maximizing health outcomes by funding cost-effective treatments, most private plans are designed to make employees happy during collective bargaining without a clear understanding of the health needs of the employees, and with a mindset that a good drug plan covers anything at any price (O'Brady, Gagnon, and Cassels 2015).

## 1.1 Types of Drug Coverage

Drug coverage in Canada falls into four main categories:

***1-Provincial and Territorial Public Drug Plans***

Provincial and territorial (PT) public drug plans account for 39% of prescription drug expenditures (Canadian Institute for Health Information 2023) but vary widely across jurisdictions (Canadian Institute for Health Information 2024). All PTs cover seniors and social assistance recipients. Coverage for social assistance recipients is generally consistent, while coverage for seniors can vary and is often income-tested (Daw and Morgan 2012). Some provinces offer catastrophic coverage for high drug costs, with deductibles ranging from 3% to 20% of annual income and co-pays between $2 and $30 per prescription (Brandt, Shearer, and Morgan 2018). Some PTs offer coverage for specific diseases or for substance use, others also provide coverage for children or for low-income people (Canadian Institute for Health Information 2024).

***2-Federal Public Drug Plans***

The federal government covers prescription drugs for First Nations people and Inuit, through the Non-Insured Health Benefits (NIHB) program that covers the costs of prescription drugs not covered by a private drug plan. The Federal Government also provides coverage for refugees, military personnel, RCMP members, and federal prisoners (Fierlbeck and Marchildon 2023). This coverage represents only 3% of total drug expenditures in Canada (Canadian Institute for Health Information 2023). Public expenditures for drugs in Canada (by provinces, territories and the federal government) are notably low compared to other OECD countries considering that only Poland, Bulgaria and Chile have a lower percentage of public expenditure (OECD 2023, 199).

### *3-Private Drug Plans*

Private drug plans, mainly provided by employers, cover 37% of total drug expenditures (Canadian Institute for Health Information 2023). Most private drug plans are provided by employers as extended health care benefits. This drug insurance pools the risks of all those covered under the policies in the same given workplace. Private premiums for drug coverage can thus be different from one workplace to the next. When private employer-provided plans that offer similar drug coverage are compared, it has been found that in workplaces where employees tend to be older, poorer, or less healthy, premiums are significantly higher than in workplaces with younger, richer, or healthier staff (Gagnon 2014).

Large employers often use "administration services only" (ASO) plans, where the insurance company administers the plan but does not assume risk. In such cases, the insurance company simply earns a percentage of spending, which creates a situation where private insurance companies have no incentive to reduce the structural costs of prescription drugs, through means such as reducing the price level of drugs or reducing overprescription and overtreatment. Smaller employers usually opt for "fully insured" plans where, for a higher fee, the private insurance company covers the risks. It is possible, therefore, that in a given the insurance company might spend more to cover risks than what it receives in premiums. However, for fully insured plans, premiums received by the insurance company are normally adjusted yearly to cover the amount in reimbursement spent the year before, to which an additional mark-up is added. Because higher spending means higher premiums with a constant mark-up rate, private insurance companies providing fully insured plans also have no incentive to reduce structural costs for prescription drugs (Gagnon 2014). Administration costs, included in the determination of the level of premiums, are not accounted for in the cost of prescription drugs, but they can become quite significant: administration costs for private drug plans are normally between 13% and 23% in Canada (Law, Kratzer, and Dhalla 2014; Himmelstein, Campbell, and Woolhandler 2020), while they vary between 1% and 2% for public drug plans (Marc-Andre Gagnon 2014; Régie de l'Assurance-Maladie du Québec 2023).

Smaller employers are getting very concerned about the sustainability of their drug benefits, especially considering that many new drugs arriving on the market have very expensive price tags (Charbonneau and Gagnon 2018). Their concerns are valid; for example, if a firm employs 50 employees and a member of the family of one of the employees starts requiring a drug treatment that costs 200,000$/year, then it would mean that private premiums for each employee on that workplace would increase by 4,000$/year once premiums are adjusted.

Private drug plans are incentivised by both federal and provincial Governments (except Quebec) through significant tax subsidies, since the premiums paid for private drug benefits are excluded from taxable annual income. This creates significant equity issues, as the richer you are, the more important your marginal tax rate becomes to you, and thus, the public subsidy you receive for your private drug coverage also becomes more important. It can be asserted that private drug plans are reliant on governments, considering 30% of the expenditures by private drug plans is used for the

private coverage of public employees, and tax subsidies offered by federal and provincial governments represent around 25% of the total cost of private drug plans (Gagnon 2012).

***4. Out-of-Pocket Expenditures***

Canadians spend 20% of drug expenditures out-of-pocket, either due to co-pays or deductibles when the person has public or private coverage, or because the person has no coverage at all (Canadian Institute for Health Information 2023). The government provides a non-refundable tax credit of 15% for out-of-pocket medical expenses, including prescription drugs, exceeding a means-tested threshold (Gagnon 2012). Financial barriers can lead to non-adherence to prescriptions, impacting health outcomes and increasing overall costs (Hennessy et al. 2016; Gagnon 2017).

## 1.2 Variation in Provincial Coverage

While each province does provide a public drug plan for many of those without private drug coverage, there is a lot of variation from one province to the next in terms of who they cover, how those eligible are covered, which drugs are covered, and the extent of out-of-pocket expenditures (Demers et al. 2008; D. J. T. Campbell et al. 2017). To illustrate this variation between provinces, we can compare three provincial plans: Ontario, Quebec and Prince-Edward Island (PEI). In these three provinces, private drug plans cover the majority of the population, and provincial public drug plans are designed to support those without private coverage.[1]

- **Ontario**

  Around 40% of the Canadian population lives in Ontario (Statistics Canada 2024). In Ontario, public drug plans cover the non-working population, specific diseases and treatments, as well as universal catastrophic coverage for people who spend over a certain threshold of their annual income on prescription drugs. There are eleven different provincial public drug plans in Ontario:

  The Ontario Drug Benefit Program (ODB) is made of three different programs for which a means-tested deductible and co-pay (up to 8.11$ per prescription) can be required: one program covers seniors (65 years old and older); one program covers low-income people receiving social assistance; and one program covers residents of long-term care homes. ODB also provides first-dollar coverage to younger people (24 and younger) not covered by a private drug plan. The Trillium program provides drug coverage to Ontario residents whose drug costs are elevated in comparison to their annual household income. Once the deductible

[1] The descriptions are based on information provided by CIHI (Canadian Institute for Health Information 2024) and the Patented Medicines Price Review Board (Patented Medicine Prices Review Board 2024), which are sources that can be consulted to obtain more details about public drug coverage in other provinces as well.

of 4% of the annual income is reached, insurees pay 2$ per prescription. Other programs cover specific diseases or treatments such as inherited metabolic diseases, RSV, intravenous cancer drugs, Visudyne, and some selected expensive drugs.

Because of catastrophic drug coverage offered by the Trillium program, it is possible to say that all Ontarians have access to some form of drug coverage. However, because of the high deductibles entailed, financial barriers to access drugs in Ontario still exist for a significant share of the working population.

- **Quebec**

  Quebec is the second most populous province with around 22% of the Canadian population based in the province (Statistics Canada 2024). In 1997, Quebec implemented a private-public system of drug coverage designed to ensure that all residents have drug coverage (Morgan et al. 2017). The system upholds the primacy of private drug coverage, which is mandatory for employees and their dependents when a private drug plan is available. Employers who want to offer health benefits to their employees must include prescription drugs, and employees cannot refuse unless they already have a private drug plan through their spouse or a different employer. Certain conditions apply both to public and private drug plans: all drugs covered by the public plan must be covered by private drug plans; monthly deductibles are limited to 22$; the co-insurance rate is limited to 32%; and total annual out-of-pocket payments for insurees must not exceed $1,196.00 (Régie de l'Assurance-Maladie du Québec 2024).

  Because private drug plans are mandatory, Quebec is the only province that does not provide tax subsidies as incentives for employers to provide drug benefits. For Quebec residents who cannot access private coverage, they are automatically covered by a public drug plan. Quebec's Public Prescription Drug Insurance Plan covers 4 different groups:

  1-Those who are 65 or over automatically have access to the public prescription drug insurance plan. Every senior without a private plan is covered by the public plan, and even if a private drug plan is available, it is not mandatory anymore for this age group, who can simply access the public plan instead. The conditions mentioned above apply (with lower annual maximal amounts to be paid out-of-pocket), and an income-based premium is also required, up to $744/year (Régie de l'Assurance-Maladie du Québec 2024).

  2-Social assistance beneficiaries are also automatically covered, without any premium or out-of-pocket expenditures.

  3-Anyone under 65 without access to a private drug plan is automatically covered. The conditions mentioned above apply, and an income-based premium is also required, up to $744/year (Régie de l'Assurance-Maladie du Québec 2024).

4-Children under 18 (or under 25 if they attend an educational institution at full-time) without access to a private plan are covered, without any premium or out-of-pocket expenditures.

The Quebec public prescription drug insurance is often considered an ideal model since every Quebec citizen has private or public coverage. However, it is not actually a universal program, because how coverage is applied, access to different drugs, and deductibles and co-pays vary between individuals. In fact, in many ways, the system is designed to artificially increase the costs of private plans, for example by imposing higher dispensing fees and prices for private plans, while using measures to contain costs for the public drug plan (Gagnon et al. 2017).

- **Prince Edward Island**

  Making up less than half of 1% of the Canadian population, Prince Edward Island (PEI) is the smallest Canadian province by population (Statistics Canada 2024). PEI Pharmacare is the payer of last resort for eleven public drug programs delivered through retail pharmacies, and for fourteen public drug plans delivered through a centralized provincial dispensary called Provincial Pharmacy. The latter public drug plans are built around specific diseases or products, including drugs or vaccines for HIV/AIDS, hepatitis, cystic fibrosis, immunization, rabies, tuberculosis, and more.

  The eleven public drug plans delivered through retail pharmacies serve diverse needs and include one program for seniors, one program for children, one catastrophic drug program, one program for high-cost drugs, one program for diabetes (and another for insulin pumps), one program specific to generic drugs, and other programs for nursing homes, home oxygen, smoking cessation drugs and sexually transmitted diseases.

  PEI's variety of public drug plans, all with different types of co-pays, for such a small population is indicative of the complexity of the current system of drug coverage. All the programs depend on specific diseases, conditions or age, except the catastrophic drug program that applies to everyone. In all cases, however, it has an annual deductible of up to 6.5% of annual income based on total household income.

## 1.3 Problematic access

In addition to the technical complexity of public and private drug plans, required deductibles, co-insurance rates and co-pays can introduce significant financial barriers to access to prescription drugs by imposing out-of-pocket expenditures. 21% of Canadians report having no drug coverage, and around 10% of the population reports not filling their prescription(s), or skipping doses because of financial barriers (Cortes and Smith, Leah 2022). The majority of those without coverage or incapable of accessing their drugs are low income workers (Bolatova and Law 2019; Barnes 2015), as well as racialized Canadians and migrants (Cortes and Smith, Leah 2022). The financial hardships suffered by Canadians due to lack of coverage or insufficient coverage must not be downplayed: many Canadians end up having to decide between buying medications or food (Patel et al. 2016; Men et al. 2019), or have to shrink their spending on housing, transit or cell phone plans (Goldsmith et al. 2017). Removing financial barriers to access prescription drugs could prevent hundreds of deaths every year, as well as thousands of hospitalizations (Lopert, Docteur, and Morgan 2018). In fact, for many types of diseases, non-adherence to treatments due to financial barriers costs more to publicly funded hospitals in terms of additional emergency room visits and hospitalizations, than what the cost would have been of first dollar public coverage for the drugs (Persaud et al. 2023; ACINP 2019, 47). When compared to countries surveyed by the Commonwealth Fund, Canada remains a laggard when it comes to access to prescription drugs (see Table 1).

Table 1

| Percentage of population not filling prescriptions or skipping doses because of cost | % |
|---|---|
| **Netherlands** | 4,5 |
| **France** | 5,0 |
| **Sweden** | 6,4 |
| **U.K.** | 7,2 |
| **Germany** | 7,3 |
| **New Zealand** | 7,4 |
| **Switzerland** | 8,5 |
| **Canada** | 10,4 |
| **Australia** | 13,0 |
| **U.S.** | 20,9 |

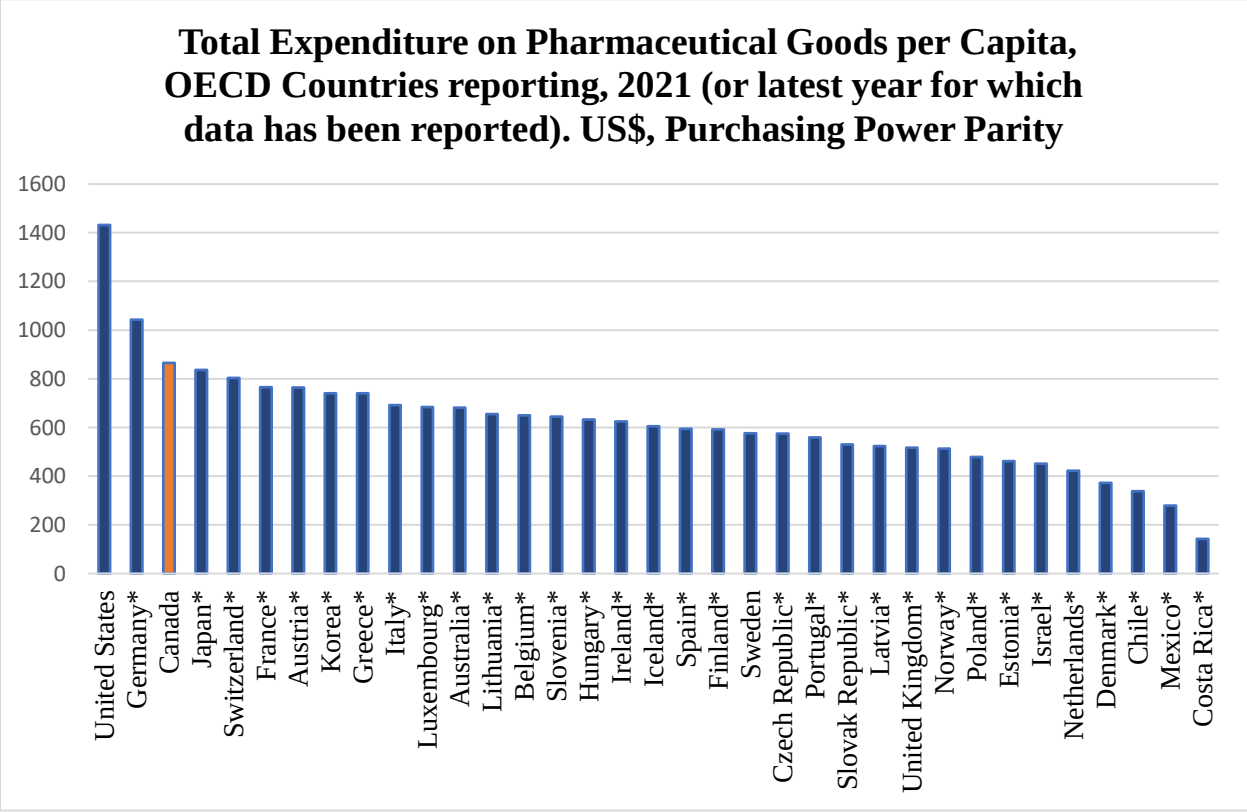
Source: Commonwealth Fund's 2023 International Health Policy Survey of the General Population

## 1.4 The High Costs of Prescription Drugs in Canada

Canada's prescription drug costs are among the highest globally. In 2023, Canadians spent approximately $41.1 billion on prescription drugs (Canadian Institute for Health Information 2023). This amount excludes another $6.7 billion spent on drugs and health supplies sold over-the-counter (almost fully paid out-of-pocket). Prescription drugs represented only 6.4% of health expenditures in 1985, and now represents 12% of health expenditures, which is more than the total amount spent for physician visits (Canadian Institute for Health Information 2023). Pharmaceutical sales in Canada represents 1.5% of Canadian GDP and 2.2% of the global pharmaceutical market, making Canada the 8th largest world market (Innovation, Science and Economic Development Canada 2024).

The cost per capita for prescription in Canada is among the highest worldwide. Canadians spend more than twice as much per capita as compared to their counterparts in the Netherlands or Denmark. When compared to other OECD countries, Canada is third in terms of cost per capita, after the United States and Germany (where the cost per capita includes a value added tax of 19%) (See Figure 1).

Figure 1




*: Expenditure includes Value Added Tax

Source: OECD Health data

Canada is characterized by both high costs per capita for prescription drugs and a significant proportion of the population who cannot access the drugs they need. This state of affairs is due to high prices and a lack of cost-efficiency.

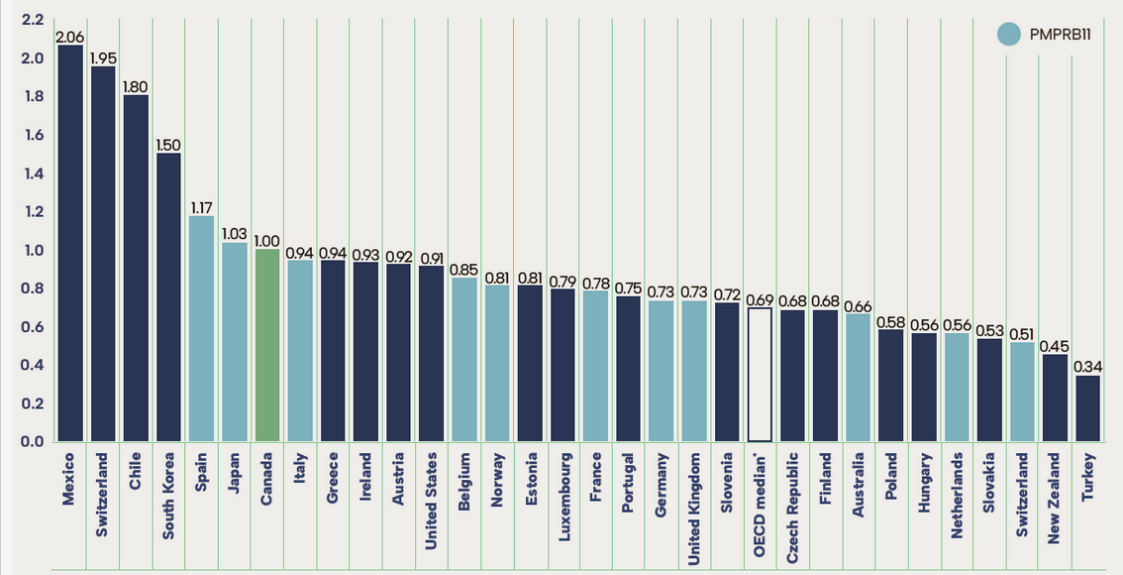
## High Official Prices

The first reason for high costs of prescription drugs in Canada is the high prices of patented drugs. When a new drug comes to the market, it is branded and patented. Once the patent expires, 20 years after the discovery of the molecule, generic competitors can enter the market and compete against the brand-name (but now unpatented) drug. While brand-name drugs normally maintain the high price of the drug as when it was patented, generics are normally sold between 8% and 25% of the price of the brand-name drug. Patented drugs represent around half the Canadian market in terms of sales, while unpatented brand-name drugs and generics each represents around a quarter of the market in terms of sales (Patented Medicines Price Review Board 2024, 27).

When it comes to the retail market, generics represent 78.6% of the market in volume, which is among the highest rates when compared with other OECD countries, but it represented only 22.8% of retail market in terms of value (OECD 2023, 205). The price of generics in Canada is considered high when compared to other OECD countries, with the Canadian average price being 45% more expensive than the OECD median (Patented Medicines Price Review Board 2024, 53). As for the price of patented drugs, Canada is the world's second most expensive countries with prices 28% more expensive than the OECD median (Patented Medicines Price Review Board 2024, 51) (see Figures 2-3).

Figure 2

**Foreign–to–Canadian Price Ratios for Generic Medicines, OECD, Q4-2022**



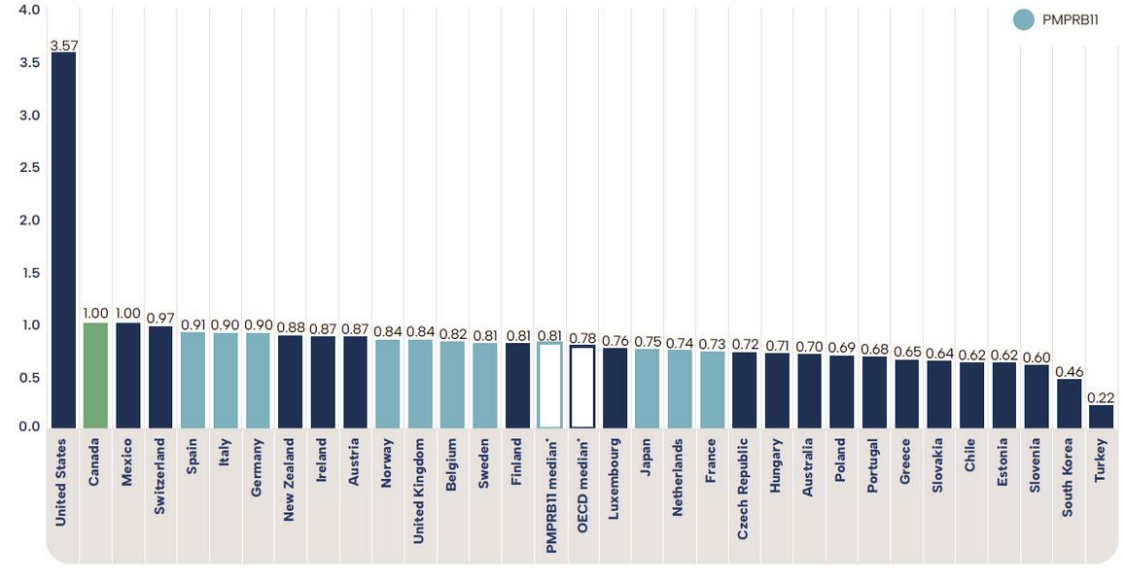

* The OECD median does not necessarily represent the median result for the individual countries reported in this graph, as it is calculated at the medicine level for generics with prices available in at least three foreign markets.

Data source: MIDAS® database, October–December 2022, IQVIA (all rights reserved)

[NPDUIS Report: *Generics360, 2018* – graph updated to 2022]

Figure 3

**Average Foreign–to–Canadian Price Ratios, Patented Medicines, OECD, 2022**




* Calculated at the medicine level for medicines with prices available in at least three foreign markets.

Data source: PMPRB; MIDAS® database, 2022, IQVIA (all rights reserved)

## Low Confidential Rebates

When analyzing the cost of patented drugs, it is crucial to recognize that the comparison of prices between countries is misleading because the global pricing model for patented drugs includes additional layers of complexity. The official prices of patented drugs (which are the prices compared in figure 3) are normally not the prices paid by drug plans, because most payers negotiate confidential rebates. This discrepancy arises because most payers negotiate confidential rebates with drug manufacturers, which are not publicly disclosed. It is estimated that the confidential rebates obtained by public drug plans is normally between 20% and 29% of the official price (Morgan, Vogler, and Wagner 2017). In Canada, public drug plans collectively negotiate these rebates through the Pan-Canadian Pharmaceutical Alliance (PCPA), which includes all provincial, territorial, and federal public drug plans. The PCPA successfully secures approximately $3.9 billion in confidential rebates annually. This level of rebate is comparable to that achieved in other OECD countries. However, almost all OECD countries have a universal pharmacare system and negotiate confidential rebates for their whole population. In Canada, PCPA negotiates confidential rebates only for public drugs plans, which represents only 42% of expenditures. Note that people insured through public drug plans still pay their co-insurance rates and deductibles based on the official price of drugs.

Private drug plans, on the other hand, have a more fragmented approach to negotiating confidential rebates. The prevailing culture within private insurance tends to prioritize broad coverage of approved drugs without substantial negotiation for rebates (O'Brady, Gagnon, and Cassels 2015). While some private insurers, like Sun Life, considered to be the most active insurer in negotiating rebates (20Sense 2022) —Sun Life reported securing $500 million in rebates from 2014 to 2023, which represents an average of $56 M annually (SunLife 2023). —this is not uniformly practiced across the industry (Barkova and Malanik-Busby 2023, 38). Even if the rebate levels achieved by Sun Life were extended to the entire private sector, they would still represent a fraction of what is obtained by public drug plans. Furthermore, there is no assurance that these rebates benefit the insured individuals rather than the insurers' shareholders. The lack of transparency in private rebate negotiations raises concerns that insurers might prioritize more expensive drugs with higher rebates rather than cost-effective drugs that offer the best therapeutic value, as is observed in the United States (Robbins and Abelson 2024; Federal Trade Commission 2024).

Because of the poor performance of private drug plans in negotiating confidential rebates, not only do Canadians pays higher official prices than other OECD countries, they also pay even higher real post-rebate prices for the same prescription drugs when compared to other OECD countries (this is even before including the additional 10% mark-up in administrative fees paid in premiums for private plans as compared to universal public systems). The fragmentation of drug coverage creates significant inefficiency when it comes to negotiating drug prices in Canada.

The inefficiencies in negotiating drug prices in Canada stem from the fragmented nature of drug coverage. A more effective approach could involve organizing bulk purchasing and negotiating rebates for the entire Canadian population through institutions that ensure that rebates are transferred to insurees. While it does not necessarily require a single-payer model, it does require that all payers accept to reimburse only drugs listed on a national formulary after agreeing on a cost-efficient price. Systematically negotiating drug prices based on their therapeutic value to ensure value-for-money could save billions in drug costs to Canadians. The Parliamentary Budget Officer has estimated that a universal pharmacare program with minimal co-pays could increase prescription drug utilization by 13.5% and reduce overall drug costs by $2.2 billion annually (Barkova and Malanik-Busby 2023). This would ensure more cost-effective and equitable access to medications for Canadians.

Canada's drug coverage system is complex and fragmented, leading to significant disparities in access and affordability. The whole system seems currently designed to artificially increase costs for patients and employers without improving the health care Canadians are getting. Addressing these challenges requires comprehensive reform to ensure equitable access to medications for all Canadians, reducing financial barriers and achieving cost-efficiency in drug pricing. Important debates exist since decades about the necessity to reform the current drug coverage system. It is important to understand these debates to better grasp what is at stake with Bill C-64; An Act Respecting Pharmacare.

# 2. The Battle for Universal Pharmacare: A Historical and Political Overview

Canada's journey towards universal pharmacare has been shaped by various federal commissions and political changes over the decades. Already, the Hall Commission of 1964, formally known as the Canada Royal Commission on Health Services, recommended the inclusion of prescription drugs to a Canadian universal healthcare coverage (Canada Royal Commission on Health Services 1964). Two other significant federal commissions highlighted the need to include prescription drugs in a universal health care program. The National Forum on Health, in 1997, recommended first-dollar coverage for all prescription drugs, emphasizing a comprehensive approach to medication access (National Forum on Health 1997). Similarly, the 2002 Commission on the Future of Health Care in Canada, commonly referred to as the Romanow Commission, advocated for a universal catastrophic drug plan as an initial step towards universal pharmacare (Commission on the Future of Health Care in Canada 2002). The Romanow Commission also recommended establishing a national formulary, a national health technology assessment system to systematically obtain value for money, and a national drug purchasing and price setting system (Commission on the Future of Health Care in Canada 2002). All these policies would have been building blocks for a universal pharmacare system (Gagnon 2014).

In 2004, the federal government, led by the Liberal Party of Canada, initiated a ten-year National Pharmaceutical Strategy (NPS) in agreement with the provinces and territories, aiming to implement the Romanow Commission's recommendations. However, the Conservative Party's victory in the 2006 federal election led to the abandonment of many of these initiatives, with the exception of extending the health technology assessment capacity of the Canadian Agency for Drugs and Technology in Health (CADTH). Notably, the proposed national catastrophic drug coverage system was discarded (Morgan et al. 2016).

Since the 1990s, most provinces and territories made only minor adjustments to their public drug coverage systems. Quebec was a notable exception, implementing its own version of pharmacare in 1997, which required mandatory private drug plans (Gagnon et al. 2017). Ontario also took a significant step in January 2018 by introducing a universal pharmacare program for individuals under 25. However, this initiative was reversed later that year by the newly elected Conservative Party of Ontario, which limited coverage to those without private insurance (Miregwa et al. 2022).

## 2.1 Re-opening the Debate (2015)

The election of the Liberal Party of Canada in 2015 revived discussions about reforming drug coverage. The rising costs, accessibility issues, and sustainability concerns surrounding both public and private drug plans intensified calls for reform.

On one side of the debate, stakeholders such as private insurers, pharmaceutical companies, and pharmacy chains supported maintaining the existing patchwork of public and private plans, advocating for merely "filling the gaps" to assist those unable to access necessary medications (Gagnon 2021). Conversely, unions, consumer organizations, community groups, and over 1,000 Canadian health professionals and experts in health care and public policy (Pharmacare 2020 2022) pushed for a comprehensive overhaul of the patchwork, and for the implementation of a universal pharmacare system for all Canadians instead. These proponents see a universal pharmacare system as not only a way to reimburse bills and provide access to those who cannot otherwise afford treatments, but also as a building block for putting in place the institutional capacity necessary for a more rational system that could reduce costs, provide value-for-money and reduce overtreatments by ensuring that prescribing habits of health care professionals are based on best available evidence (Morgan et al. 2016).

A report commissioned by the Standing Committee on Health of the House of Commons in 2016, published in 2018, endorsed the implementation of universal pharmacare in Canada (Casey 2018). Studies suggested that such a system could not only improve access to prescription drugs in Canada, but could also save between 10% and 40% of current costs ( Gagnon and Hébert 2010; Morgan et al. 2015) This was further corroborated by a 2017 report from the Parliamentary Budget Officer (Malanik-Busby et al. 2017). The central issue of cost-saving is contentious, as savings for Canadians translate into lost income for drug manufacturers, private insurers, and pharmacy chains, leading these stakeholders to, unsurprisingly, resist changes and advocate for a gap-filling approach (Gagnon 2021).

## 2.2 The Hoskins Report (2019)

In February 2018, the Government of Canada established the Advisory Council on the Implementation of National Pharmacare (ACINP), chaired by former Ontario Health Minister Eric Hoskins. The Council was tasked with developing an implementation plan for a National Pharmacare program. However, there was significant pressure from the Liberal Party to recommend a "fill the gaps" model rather than a complete overhaul (Blatchford 2018; Forrest 2018).

In 2019, the ACINP released its final report, commonly known as the "Hoskins report," which argued that a fill-the-gap approach was unsustainable. Instead, it proposed a model for implementing universal pharmacare and offered a clear roadmap to achieve it with minimal resistance (ACINP 2019). The main recommendations of the report centred around pieces that would allow for the prudent implementation of universal pharmacare by organizing prescription drug coverage in the same way universal health coverage is set up in Canada, and by capping out-of-pocket expenditures at $100 per household per year for drugs listed on a national formulary

(ACINP 2019). As with Medicare, it would be up to individual provinces and territories to opt in to the universal pharmacare program by agreeing to national standards and funding parameters. The federal government would pay for the incremental costs to provinces and territories for expanding coverage and implementing pharmacare in their jurisdictions. Part of the national standards would be to reimburse all drugs listed on a national formulary, but provinces and territories could decide to reimburse additional drugs if they want. More importantly, employers could also provide additional coverage if they want to, which would make sure that the federal government would not be taking away private coverage from any employee (an important talking point of groups opposed to universal pharmacare (Gangcuangco 2024; Gagnon 2021)). The phased implementation would proceed as follows:

1. **Creation of a Canadian Drug Agency**: This agency would manage a national formulary of reimbursed drugs, negotiate confidential rebates, collect data on drug utilization, and provide prescribing guidelines.
2. **Phased Implementation**: Starting in January 2022, the program would initially cover a basket of essential medicines,[2] with a gradual extension of coverage through negotiations with manufacturers to ensure value-for-money. Comprehensive universal pharmacare would be fully realized by 2027.
3. **Coverage for Rare Diseases**: Specific pathways for reimbursing drugs for rare diseases would be established by 2022.

The Hoskins report proposed a gradual build-up, starting with foundational elements to prove the concept before expanding the program. This phased approach aimed to minimize disruption and allow stakeholders time to adjust. Following the report's release, the Liberal Government committed to implementing universal pharmacare and adopting the report's recommendations (Webster 2019).

## 2.3 Steps Forward, Steps Back

Progress towards implementing the Hoskins report recommendations was initially slow. In 2019, the federal budget allocated funds for creating a national drug agency (Young 2019). However, the COVID-19 pandemic in 2020 disrupted these efforts. The pandemic shifted the focus of federal-provincial relations, revealing the critical state of long-term care facilities and prompting the federal government to consider establishing national standards for this area of healthcare (Estabrooks et al. 2020). This focus led to pushback from provinces and territories, who viewed

[2] Essential medicines normally cover most of the health needs of a population and they are also less expensive (Taglione et al. 2017).

increased federal involvement in healthcare as encroaching on their constitutional jurisdiction (Gallant 2020). Consequently, discussions about universal pharmacare stalled.

The only significant movement since the pandemic has been the 2021 agreement between PEI and the federal government in 2021 (Wilson 2021), which saw the federal government commit to additional funding for PEI's existing 29 public drug plans (Health Canada 2021), without implementing a universal pharmacare program in the province .

In 2022, a political shift signaled a potential renewal of pharmacare initiatives. The 2021 federal election resulted in a minority government for the Liberal Party, which, in March 2022, entered a Confidence and Supply Agreement with the New Democratic Party (NDP) (Office of the Prime Minister of Canada 2022). This agreement included a condition for advancing universal pharmacare based on the Hoskins report's recommendations (Lexchin 2022; Office of the Prime Minister of Canada 2022). As a result, legislation to introduce the first phase of a national pharmacare program, Bill C-64 *An Act respecting Pharmacare*, was introduced in the House of Commons on February 29, 2024 (Health Canada 2024a). The Confidence and Supply Agreement was officially ended in September 2024 while Bill C-64 was already awaiting ratification at Canadian Senate. The end of the Agreement does not automatically trigger an election, which means that, as of September 13 2024, Bill-64 is unlikely to die on the order paper.

# 3. Bill C-64, An Act Respecting Pharmacare

Bill C-64 only proposes to cover contraceptives and drugs for diabetes. While the basket of covered drugs is much smaller than the basket of essential medicines recommended by the Hoskins report, it still creates the ability to implement the institutions necessary for a national pharmacare system, and it also begins testing of the concept overall. The bill is designed to allow the basket of reimbursed drugs to be expanded in the future. The Federal Health Minister would also have to negotiate with each province and territory to determine the details and conditions to allow funding of the universal coverage for listed drugs, without any out-of-pocket payments from patients. The details of what would be included in the negotiations remain obscure. As of now, Bill C-64 has passed its third reading in the House of Commons and awaits Senate ratification.

## 3.1 Coverage for contraceptives and diabetes products

The inclusion of contraceptives, such as oral birth control pills, intrauterine devices (IUDs), and implants (Health Canada 2024b), represents a progressive stance on maternal and women's health. Both the Liberal Party under Justin Trudeau and the NDP under Jagmeet Singh have emphasized feminist values, aligning with this approach. In particular, universal coverage of contraceptives can significantly benefit many Canadians by removing financial barriers and preserving patient confidentiality. An American study found that providing free access to contraceptives could reduce unplanned pregnancies by 32% (Bailey 2023). Covering contraceptives through a universal public pharmacare plan not only removes financial barriers to access contraceptives, but also preserves confidentiality. Patients accessing coverage through a private plan face concerns regarding these drugs and devices appearing in the plan's reimbursement billing history, which may be viewable by others, such as their parents or partner; compromising the confidentiality necessary for some women to access these products. However, access through a universal plan would not have this same weakness, as the patient's history would be viewable to them alone. A fill-the-gaps approach would make this privacy advantage of universal coverage inaccessible to anyone with a private plan; universal access is therefore the best way to preserve patient confidentiality (Albanese 2024; Action Canada 2022).

The choice to cover products for diabetes is also very important considering the significance of the socio-economic disparities that exist regarding access to these drugs (Ladd et al. 2022; Giruparajah et al. 2022). A 2012 study estimated that first-dollar coverage for diabetes products

could save over 700 lives annually in Ontario alone (Booth et al. 2012). Improved adherence to treatments would likely reduce hospitalizations and medical visits, resulting in significant savings for non-drug-related healthcare expenditures (Isaranuwatchai et al. 2020).

## 3.2 A Bill Deceitful by Design?

When submitted in on February 29 2024, *Bill C-64; An Act respecting Pharmacare*, was clearly written in haste to respect a deadline imposed for maintaining the Confidence and Supply agreement between the Liberals and the NDP. The wording of the Bill, while clearly building on the Hoskins report and calling for universal pharmacare, remains equivocal and could lead to potential challenges and unintended consequences.

Among potential challenges, agreements with provinces and territories will be necessary, and resistance from some provinces is likely. Additionally, commercial interests benefiting from the current inefficient and wasteful system continue to lobby against universal pharmacare and for Bill C-64 to keep the door open for a "fill-the-gap" approach in which public coverage would be offered only to those without existing private coverage (McLauchlan 2024). More concerning, the Minister for Health himself, Mark Holland, has hinted that Bill C-64 would allow future federal-provincial agreements to be based on a fill-the-gap approach rather than a universal system (CPAC 2024). Furthermore, the amount of funds allocated in the federal budget to implement national pharmacare also indicates that it may only cover existing gaps, without providing real universal coverage for Canadians (Campbell 2024).

While Bill C-64 seems clear about implementing a single-payer universal pharmacare model, the wording of the bill remains vague enough to allow for different interpretations (Sanci 2024; Morgan and Herder 2024). This ambiguity in Bill C-64 raises the question: is the Bill designed to entrench a "Fill-the-Gap" approach in Canadian drug, while claiming to the contrary that it would implement a universal pharmacare? If it is the case, then the only conclusion would be that the bill is designed to be deceitful. The bill is clear that its purpose is to implement the building blocks of a universal pharmacare program by beginning with the coverage of contraceptives and diabetes products. However, interpreting some of the wording in ways that are different with the normal use of these words in Canadian social and public policy could allow using Bill C-64 to entrench a "Fill-the-gap" approach to the detriment of all the benefits we could obtain with universal pharmacare. Such interpretation could be deceitful and the Canadian Senate has a role to play to protect Canadians against a potential perversion of the bill.

The role of the Senate is not to oppose the will of the House of Commons but to ensure that the policy process is sound and that the legislations are not flawed against the interests of Canadians.

It is the role of the Senate to ensure that the bill will be used to implement what it says it will implement, and that it will not be interpreted in a peculiar, convoluted and antidemocratic way to implement the opposite of what it says it will implement.

## 3.3 Two necessary amendments

The Bill could benefit from an overhaul that could clarify its different dimensions, including by setting explicitly the governance structure of the Canadian Drug Agency or by identifying clear criteria to allow funding to provinces or territories. However, these improvements would be just that: improvements to the bill. The main concern here, however, is that the bill could be deceitful by design, and it is necessary to simply focus on (minimal) amendments that would close the door to a deceitful interpretation of the bill. To do so, all that would be necessary would be to simply include the definition of two words to ensure that they are being used in the bill in the same way that they are normally used in public or social policy debates in Canada.

***First amendment: Defining "pharmacare"***

In Bill C-64, Pharmacare means "a program that provides coverage of prescription drugs and related products" (régime d'assurance-médicaments). However, Pharmacare has always meant a public program, not just any type of drug coverage. To avoid any misinterpretation, the definition of "Pharmacare" must be changed to mean "a public program that provides coverage of prescription drugs and related products".

***Second amendment: Defining "universal"***

A universal program refers to the concept of universality, well defined in social policy (Béland, Marchildon, and Prince 2019; Prince 2014). Here's an excerpt on the concept of universality, as found in the Canadian social policy textbook *Universality and Social Policy in Canada* (Béland, Marchildon, and Prince 2019, 4):

> Universality as a distinctive governing instrument in social policy refers to public provisions in the form of benefits, services, or general rules anchored in legislation instead of discretionary public sector programming or provisions in the private sector, the domestic sector, or the voluntary sector, including charitable measures. Accessibility rests on citizenship or residency irrespective of financial need or income, and the benefit or

> service or rule is applicable to the general population (or a particular age group, such as children or older people) of a political jurisdiction. The operating principle for universal provision is of equal benefits or equal access. A further expression of this general sense of political community is that financing universal programs is wholly or primarily through general revenue sources. This points to the direct link between general taxation and universality because, in contrast to social insurance programs such as Employment Insurance and the Canada Pension Plan, which are typically financed through dedicated payroll contributions, universal programs depend on the flow of general fiscal revenues associated with income and sales taxes.

The program design feature of universality means that a program provides goods and services according to criteria other than individual or family income. It is not determined by a test of means or income. While people can sometimes opt-out or refuse the benefits of a universal program if this is their preference, a universal program is a public program offered to everyone.

"Universal coverage" cannot mean that coverage is provided to everyone one way or the other, some through public coverage and others through private coverage. For example, the Quebec Pharmacare regime covers everyone in the province through a mix of private and public coverage; Quebec calls it a "general regime" (not a "universal regime") because, if the regime provides coverage to all, it does not fit the definition of "universal" as used in social policy. The word "universal" does not appear anywhere in its "Loi sur l'assurance-médicaments" (A-29.01) or in its "Réglement sur le Régime général d'assurance-médicaments" (A-29.01, r.04). In contrast, the word "universal" appears eleven times in Bill C-64. If Bill C-64 can be interpreted as to implement drug coverage similar to the one in Quebec, then the word "universal" in Bill C-64 would be meaningless.

For the second amendment, it is suggested to include the definition of "universal". We suggest to include an additional paragraph to the definitions section: "Universal refers to universality as a program design feature; which means that it is provided to all citizens regardless of means, income, or access to private benefits. A universal pharmacare program is a public program that provides coverage of prescription drugs and related products to all Canadians".

By clarifying the meaning of the words "Pharmacare" and "Universal" to ensure that they are being used in the way they are normally used in Canadian political culture and public policy, the Senate would thus ensure that Bill C-64 is not designed in a deceitful way.

# 4. Conclusion

The current patchwork of public and private drug plans creates high costs and does not provide good access to prescription drugs for Canadians. Bill C-64 might be groundbreaking for public drug coverage in Canada. While it is a very small step, as it covers only contraceptives and diabetes products, it could still be the small step that allows for the implantation of the institutional capacities necessary to create an efficient national drug coverage system that could replace, in the long run, the existing patchwork of tens of thousands of public and private drug plans.

At the time of writing, it is still unclear if, in the end, anything was achieved in the reform of drug coverage in Canada. The soon to be ratified bill could end up being a game changer that could transform the landscape of drug coverage in Canada. It could also end up even further entrenching the current inefficient, inequitable and wasteful mishmash of drug plans that has characterized Canadian drug coverage since the 1960s.

By implementing the two necessary amendments described above, the Senate could make sure that this Bill is designed as the transformative step it claims to be, and not as a ruse to entrench a regressive “Fill-the-gap” approach.

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