National Pharmacare in Canada: Choosing a Path Forward

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DEFINITIONS

CLEAN Meds list
A list of essential medicines adapted from the list created by the World Health Organization for primary care.

Coinsurance
Cost-sharing mechanism in which the insured person pays a portion (percentage) of the price of the prescription drug.

Copayment
Cost-sharing mechanism in which the insured person pays a set amount of the price of the prescription drug.

Deductible
Cost-sharing mechanism in which the insured person must pay a certain amount out-of-pocket before the drug insurance begins to pay.

Out-of-pocket Maximum (Max OOP)
Cost-sharing mechanism in which the insured person can only pay a maximum out-of-pocket amount before coverage is extended to 100%.

ACRONYMS

CAF	Canadian Armed Forces
CHA	*Canada Health Act*
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CSC	Correctional Services Canada
EPS	Electronic Prescribing System
HESA	House of Commons Standing Committee on Health
IFSD	Institute of Fiscal Studies and Democracy
NIHB	Non-Insured Health Benefits
OECD	Organisation for Economic Co-operation and Development
PBO	(Office of the) Parliamentary Budget Officer
pCPA	pan-Canadian Pharmaceutical Alliance
PMPRB	Patented Medicine Prices Review Board
RCMP	Royal Canadian Mounted Police
R&D	Research and Development
VAC	Veterans Affairs Canada

PROVINCIAL, TERRITORIAL, AND NATIONAL SHORT FORMS (in alphabetical order)

AB	Alberta
AUS	Australia
BC	British Columbia
CAN	Canada
ENG	England
FRA	France
GER	Germany
MB	Manitoba
NETH	Netherlands
NB	New Brunswick
NZ	New Zealand
NL	Newfoundland and Labrador
NT	Northwest Territories
NS	Nova Scotia
NU	Nunavut
ON	Ontario
PE	Prince Edward Island
QC	Quebec
SK	Saskatchewan
YK	Yukon

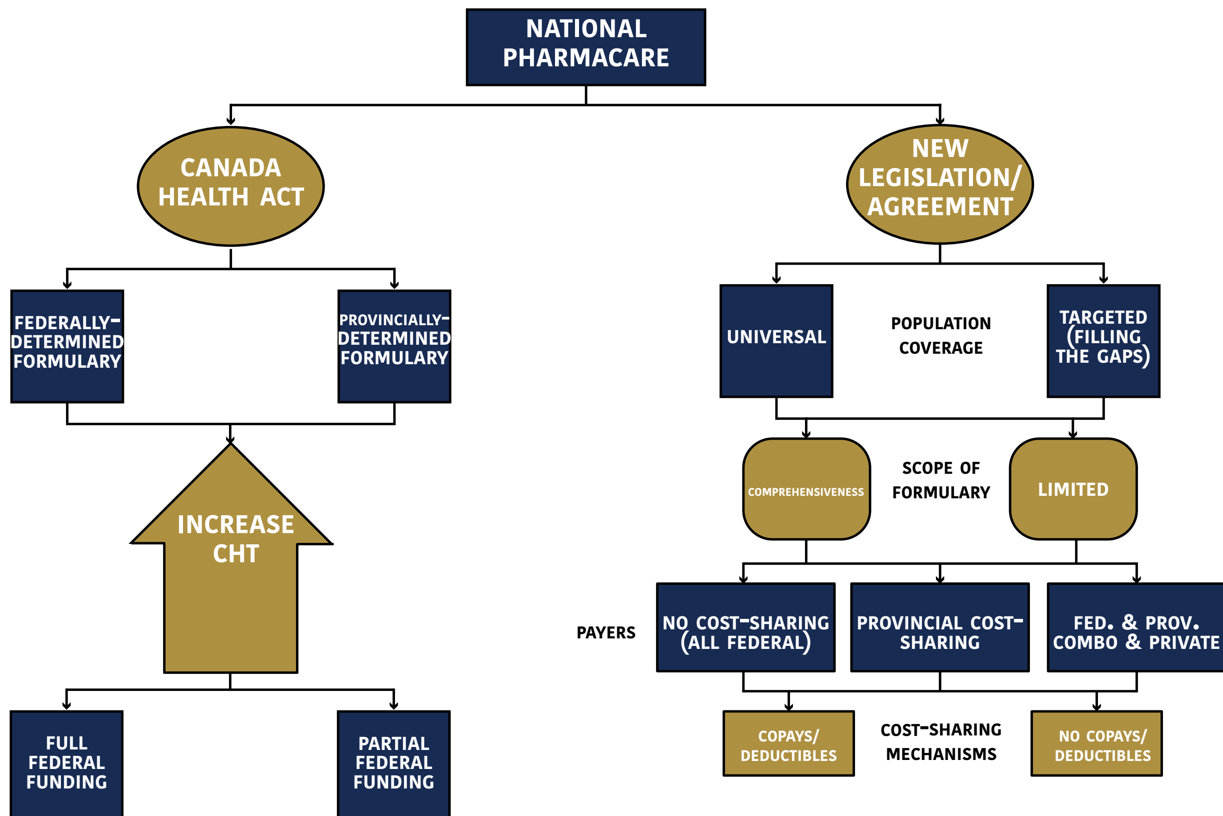
EXECUTIVE SUMMARY

National pharmacare is once again at the forefront of the health care discussion in Canada. Propelled there by the announcement of an Advisory Council on the Implementation of National Pharmacare in the 2018 federal budget, a renewed sense of both optimism and urgency has gripped policymakers and stakeholders alike. Indeed, Canada could soon join most of the other advanced economies around the globe with universal health care systems that offer pharmacare to their citizens.

But having been recommended by seemingly every commission and panel on health care ever assembled, national pharmacare is not a new concept for many Canadians. This report very briefly outlines the history of ambitious recommendations that have been consistently short on follow-through. It then outlines the legislative and policy context that currently exists for pharmacare in Canada, including the *Canada Health Act* (the *Act*) and the recent report from the House of Commons Standing Committee on Health (*Pharmacare Now: Prescription Medicine Coverage for all Canadians*), among others. The June 2018 discussion paper on national pharmacare from the federal Ministers of Finance and Health also helps to inform this analysis. This context is then set against the existing federal-provincial-territorial pharmacare landscape in Canada, with its assortment of available drugs and eligibility requirements. Lessons learned from other jurisdictions that offer national pharmacare are examined as well.

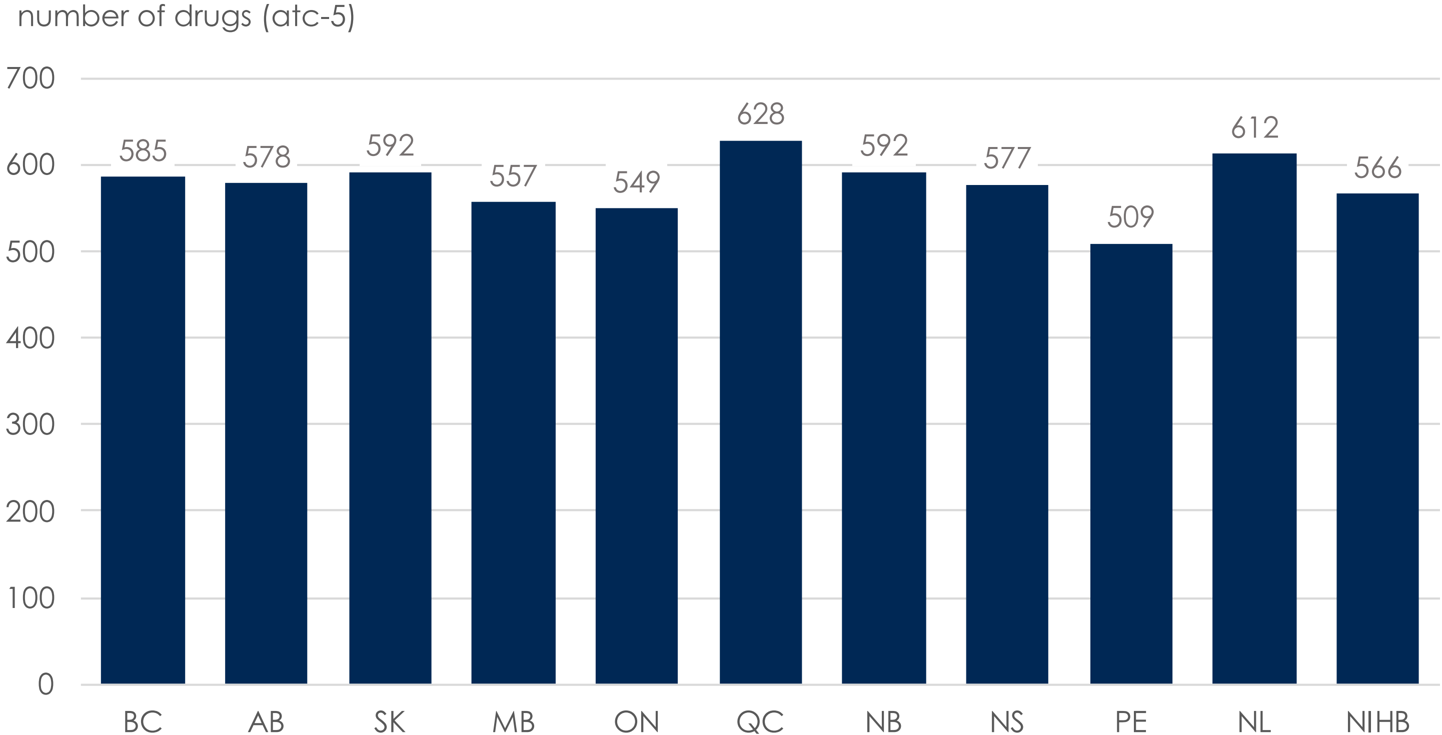
Taking all of this information into account helps to narrow the decisions that federal and provincial-territorial politicians are going to need to make as they negotiate a national pharmacare program. These negotiations will begin in earnest at the Council of the Federation meetings in New Brunswick in July 2018, and will continue through to the next federal election in October 2019. Chart A outlines the structure of the decisions that must be made in order to design a national pharmacare program.

Chart A: National Pharmacare Decisions



The first decision legislators need to make is in regard to whether national pharmacare should be introduced as an amendment to the *Canada Health Act*, a separate piece of legislation, or an agreement which will expire after an agreed-upon period. Evidence suggests that a national pharmacare plan that applies the five principles of the *Act* – public administration, universality, accessibility, portability, and comprehensiveness – would lead to superior outcomes. But there are some potential drawbacks to introducing it as an amendment to the *Act* itself. For instance, if provinces and territories are held to providing a federally-determined formulary (list of drugs) in order to receive the Canada Health Transfer (CHT), and future fiscal restraints on the part of the federal government could leave the provinces on the hook. In contrast, if provinces and territories are left to determine which drugs are considered medically necessary, Canada could remain a patchwork of federally-funded public drugs plans that is national pharmacare in name only. Chart B demonstrates the variation in current formularies across Canada although it does not show the various levels of coverage and cost-sharing mechanisms, which can be found in Annex 1.

Chart B: Drug Coverage of Canadian Formularies



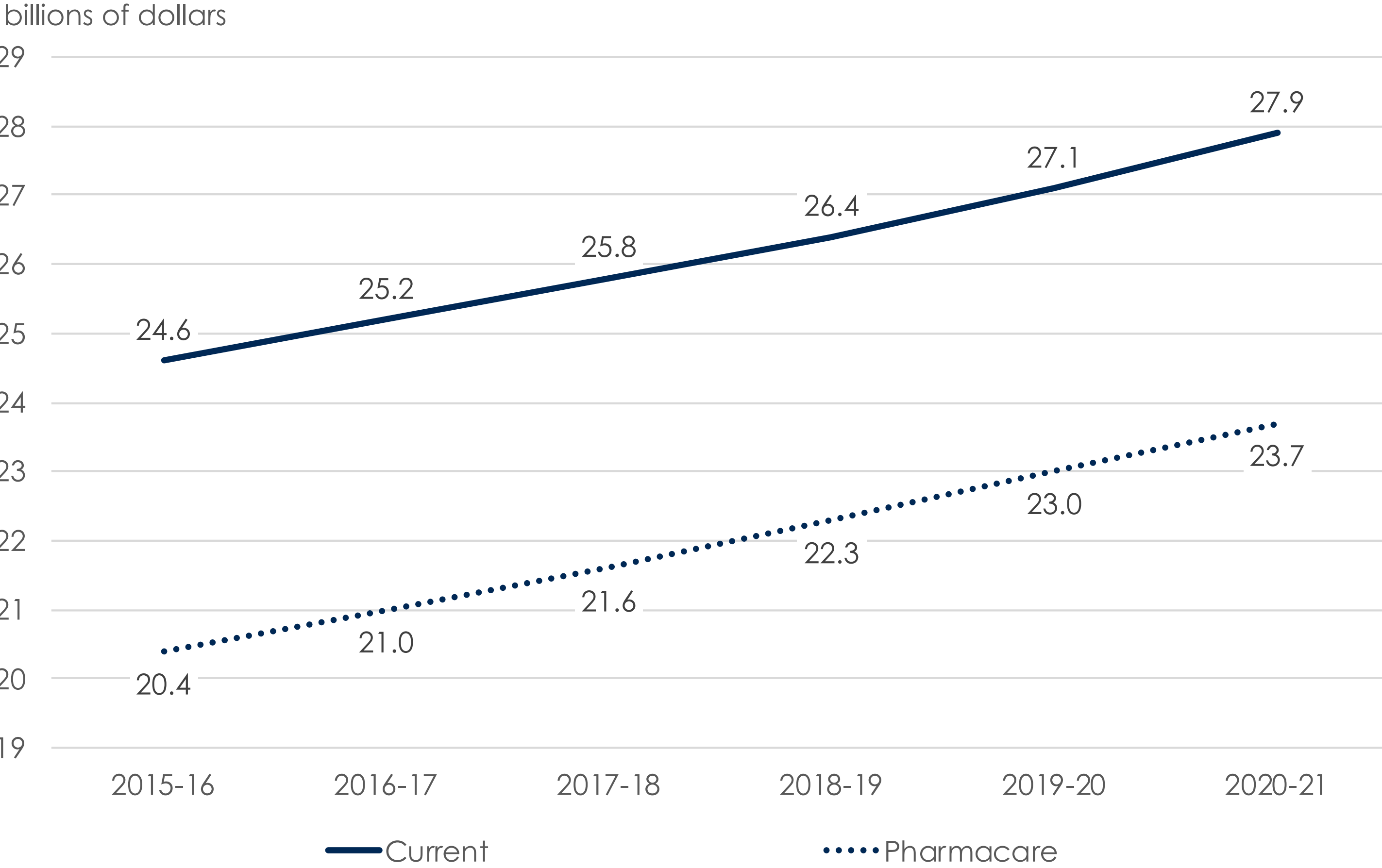
Source: Patented Medicine Prices Review Board (PMPRB).
Notes: PMPRB analysis using CIHI's NPDUIS Database calculated the number of drugs using the ATC-5 classification. As such, several unique drugs with the same active ingredient are lumped together to represent one drug. There are 1,456 drugs listed on at least one publicly-funded formulary in Canada. For this study, the PMPRB selected 729 drugs, representing 82.6% of total drug costs. Drugs for specialized programs or with limited data were excluded from the study.

Instead, if national pharmacare is the product of an agreement which will expire after an agreed-upon period as opposed to a separate piece of legislation, national pharmacare could be here today and gone tomorrow. This is why, at the IFSD, we believe that national pharmacare should be introduced under a separate piece of legislation, although one that is independent of the *Canada Health Act*.

Legislators must then decide whether national pharmacare should be universal or targeted toward specific groups. The Canadian health care environment today lends itself to this question, as it is not only shaped by the *Canada Health Act* and other federal legislation and policies but also by current programs from coast to coast to coast. While provincial-territorial health insurance plans may vary across all jurisdictions, they must all follow the five principles of the *Act*. However, even with these constraints, public drug coverage programs across Canada are all significantly different from each other. This hodgepodge of pharmacare offerings would make a targeted national pharmacare program extremely complicated and nearly impossible to implement efficiently. As such, at the IFSD, we believe that national pharmacare should be universal.

After addressing the enabling legislation and recipients of national pharmacare, legislators must then decide how expansive the formulary will be that is applied. Will it be an open formulary? A formulary that is limited, to say essential medicines or most-frequently-prescribed drugs? Or a more comprehensive formulary that is somewhere in between? At the IFSD, we believe that national pharmacare should, at a minimum, include a formulary that covers essential medicines. But we also believe that this should be the starting point for a more comprehensive formulary that goes beyond either essential medicines or most-frequently-prescribed drugs, thereby ensuring all Canadians have the opportunity to access medicines which will support better health and well-being.

Chart C: Total Spending on Drugs Eligible for Pharmacare

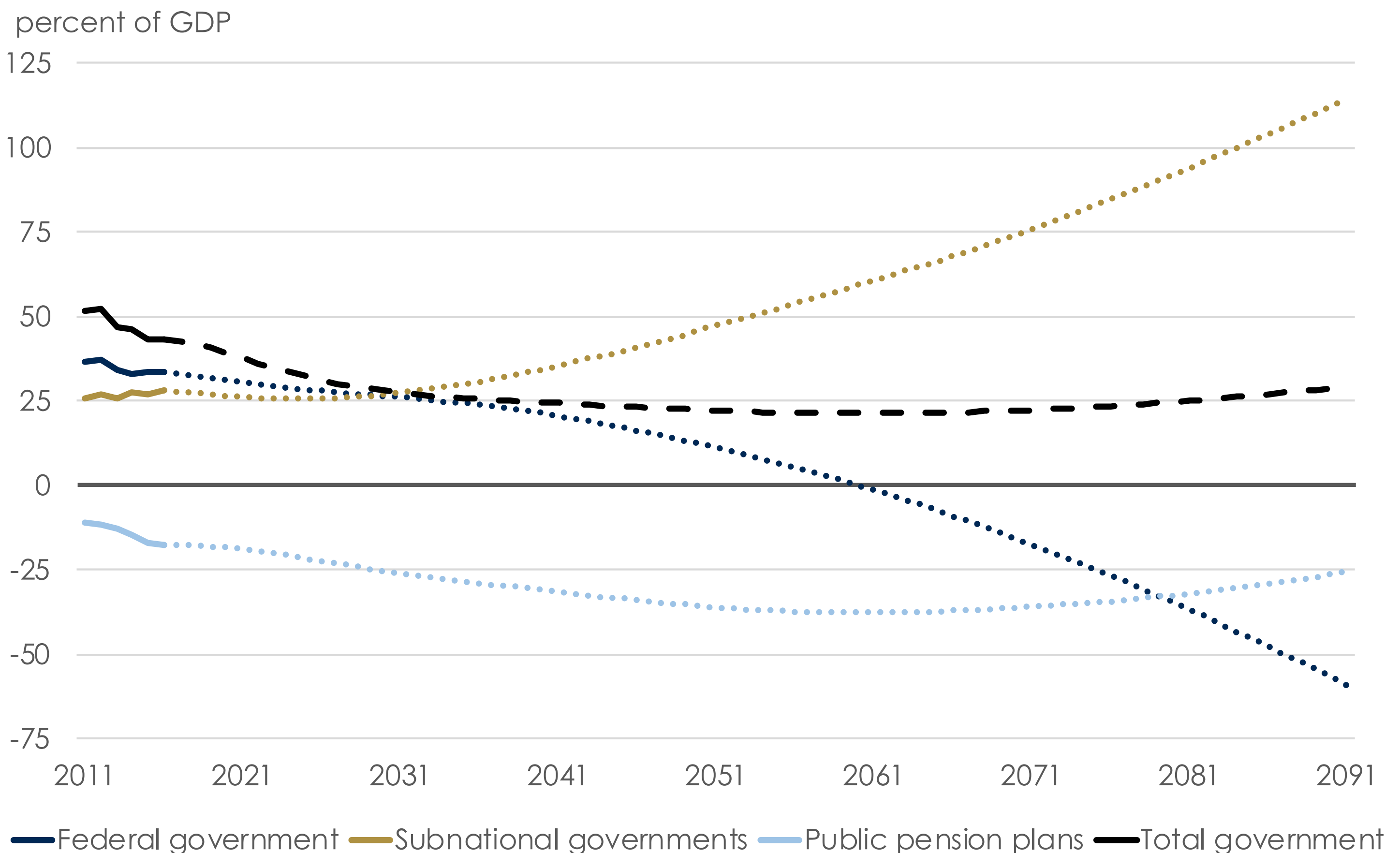


Source: Parliamentary Budget Officer, Federal Cost of a National Pharmacare Program, 2017.

But this recommendation of universal, comprehensive national pharmacare does not come for free. And while research from the Parliamentary Budget Officer (PBO) and others tell us that Canadians will experience aggregate cost savings with national pharmacare (Chart C), we must not forget that the cost will migrate from consumers and employers to various orders of government.

This begs the question: Who will pay for national pharmacare? For instance, the IFSD applied the PBO (2017a) projected cost of national pharmacare using Quebec's comprehensive formulary to the federal government's fiscal projection from Budget 2018: as a consequence, even though the federal government is currently in a fiscally sustainable position, it would not be sustainable for the federal government to bear the entire burden of national pharmacare using Quebec's formulary. This remains the case even with small copayments. And because subnational governments collectively are not currently in a fiscally sustainable position, any agreement that shares the cost of the program between the federal government and provincial-territorial governments will be a difficult sell (Chart D).

Chart D: Government Net Debt relative to GDP



Sources: Statistics Canada, Parliamentary Budget Officer.
Notes: The projection period covers 2017 to 2091, and can be found in the PBO's Fiscal Sustainability Report 2017.

This leaves a couple of options. First, the federal government could assume the entire cost of a comprehensive formulary for national pharmacare but could raise revenues or cut spending to pay for it. For instance, if the federal government raised the Goods and Services Tax (GST) by two points, from 5% to 7%, it could likely pay for national pharmacare with a comprehensive formulary while remaining fiscally sustainable. Alternatively, the federal government could remain in a fiscally sustainable position without raising revenues or cutting spending if it was to introduce a much more

limited formulary, such as an essential-medicines or most-frequently-prescribed-drugs list. At the IFSD, we believe that all governments should strive to be in a fiscally-sustainable position, at a minimum, and hope they strive to do so in the most economically-efficient way possible.

But governments are not the only possible payers for national pharmacare. The private sector can also participate in paying for drug coverage, as it can top-up national pharmacare. However, a single-payer national pharmacare program is generally considered to be more efficient both fiscally and administratively. Further, it allows for the principles of the *Canada Health Act* – such as universality and accessibility – to be more easily included in national pharmacare.

Of course, the consideration of cost-sharing mechanisms with patients is also important and, in the international context, copayments are very common. However, since research has shown that even small copayments and deductibles limit accessibility to prescription medicines, excluding such mechanisms from a national pharmacare program would better help to achieve the outcome of increased access to drugs for all Canadians. Therefore, if copayments and deductibles are to be a component of national pharmacare, provincial-territorial programs should remain in place, and possibly expanded, to protect the vulnerable populations that would have access to pharmaceuticals hindered due to such cost-sharing mechanisms. These include low-income households, seniors, and people with disabilities, among others.

Finally, by looking at all of the various components of a national pharmacare program and how it will be delivered, it is clear that performance criteria are crucial to hold provinces and territories accountable for the funding received. The development of national pharmacare will involve many decisions, but it is the right combination of coverage, funding, and performance reporting that will allow Canadians to realize the desired outcomes.

The time has come for national pharmacare in Canada. It is now up to federal and provincial-territorial legislators to make it a reality.

Pharmacare has come and gone from the minds of Canadians and politicians over the years, resurfacing now and again with the latest federal report or commission on health care in Canada. But pharmacare continues to loom large over health care discussions in Canada. Now, in 2018, the concept of pharmacare has re-emerged as a major policy issue, having been placed in the window by the federal government. Indeed, Budget 2018 established an Advisory Council on the Implementation of National Pharmacare to further explore the policy environment.

But what could a national pharmacare program in Canada look like? The answer to this question will very much stem from the goals that we want a national pharmacare program to accomplish and the constraints within which it is initiated. In this report, the Institute of Fiscal Studies and Democracy (IFSD) examines the current context in the hope of distilling the choices of the federal government down to a narrow set of decision points. To do this, the IFSD:

- Provides definitions of pharmacare-relevant concepts to be used in the IFSD's analysis;
- Gives a brief history of the debate around pharmacare in Canada;
- Outlines the legislative and policy environments in order to give context, beginning with the *Constitution Act, 1867*, through to analysis published just prior to the Council of the Federation meeting in New Brunswick in July 2018;
- Evaluates the assortment of existing provincial and territorial health care regimes, including drugs covered under existing formularies and groups covered under existing health care programs, as well as those individuals covered by federal drug programs;
- Examines pharmacare programs in other countries and their applicability to Canada;
- Analyzes the different cost estimates of alternative national pharmacare programs; and
- Identifies a narrow set of ways forward for discussion among federal and provincial-territorial politicians, as well as other stakeholders.

Deciding what a national pharmacare program hopes to accomplish is the first step in its design. Depending on what the desired outcomes are for all levels of government, different structural considerations will be more relevant for the program than others. This report will discuss the various possible options and provide context around what is suitable for achieving the desired outcomes. In the end, the decision regarding the desired outcomes of a pharmacare program must be made and will affect what pharmacare in Canada will look like for years to come.

CONTEXT

SOME HELPFUL DEFINITIONS RELATED TO PHARMACARE

Before we can explore the opportunity for a national pharmacare program in Canada, we must first define what it is. Looking to the HESA report, pharmacare is defined as “a universal single payer public prescription drug coverage program”.[1] For completeness, an alternative definition explored in the HESA report is the “reform of the existing system of public and private prescription drug coverage through closer collaboration between the public and private sector and targeted efforts to address gaps in coverage.” However, HESA rejects this definition, stating that “the Committee has concluded that merely addressing coverage gaps will not lead to better health outcomes or better cost control.” According to the HESA report, a single-payer model is also more efficient than a multi-payer system, through “administrative, economic and informational economies of scale”.[2] For these reasons and others, IFSD has chosen to explore the first definition only, and the following analysis will flow from this definition.

In addition to the working definition of pharmacare to be used in this report, there are several other definitions that will prove useful. For instance, according to the HESA report, “a *formulary* is a list of drugs whose costs are covered by a drug coverage program.” But even this broad definition requires some refinement. Indeed, within the concept of a formulary, there are three other important ideas. First is an *open formulary*, “where all drugs approved for sale are included,” according to discussion paper from the Ministers of Health and Finance. This is the broadest conception of a formulary. In contrast are those formularies that include only *essential medicines*, which the World Health Organization (WHO) defines as “those (medicines) that meet the priority health care needs of the population and should be available within the context of functioning health systems at all times in adequate amounts and at a price the individual and the community can afford” – these are much more constrained (Ministers of Health and Finance, 2018. “Another approach would be to focus on the *most frequently prescribed drugs* across a broad range of common medical conditions (e.g., diabetes, high blood pressure, etc. […] Alternatively, a more comprehensive approach could be taken by providing coverage for a larger list of drugs equivalent to what some of the more generous provincial formularies currently provide (although not an open formulary where all drugs approved for sale are included” (Ministers of Health and Finance, 2018. With these definitions in hand, we will explore the opportunities for various formularies under a national pharmacare program in Canada.

A BRIEF HISTORY OF THE PHARMACARE DEBATE IN CANADA

The concept of universal public coverage of prescription drugs is not new for Canadians. In fact, it was recommended by the 1964 Royal Commission on Health Services (also known as the Hall Commission, the 1997 National Forum on Health, and the 2002 Royal Commission on the Future of Health Care in Canada (better known as the Romanow Commission.[3]

The 1964 Hall Commission suggested that prescription drugs should be an insured benefit of the health care system. In his report, Emmett Hall, the Chief Justice at the time, focused on the specific challenges that government would face in the implementation of a drug coverage program, something that has been the subject of debate for years since. Even then, there existed an excessive need for prescriptions, the over-prescribing of drugs, and a lack of data available for benchmarking.[4] These challenges still ring true in 2018. Although Chief Justice Emmett Hall was a key contributor to the health care system Canadians experience today, his recommendation for a drug coverage program was not accepted.[5]

Following the Hall Commission, the National Forum on Health was chaired by Prime Minister Jean Chrétien in 1997. This advisory panel reached a similar conclusion to that which Chief Justice Emmett Hall did in 1964. The National Forum on Health recommended that provinces provide prescription drug coverage and, similar to what will be explored later, that brand name drugs should be accompanied by a cost-sharing mechanism when equally effective generics are available.[6] However, despite public drug coverage being recommended once again, Canada did not implement a pharmacare program.

Almost exactly five years after the National Forum on Health was announced, the report from the Commission on the Future of Health Care in Canada was announced in 2002. Headed by Roy Romanow, the Commission report recommended a familiar policy – the implementation of medically necessary prescription drug coverage.[7] Romanow specifically recommended a form of catastrophic drug coverage which would protect Canadians against exceptionally high drug costs that could hurt their financial stability. Unlike past reports and commissions, Romanow's recommendations were visibly implemented across the health care system, from catastrophic drug coverage to the pan-Canadian Pharmaceutical Alliance, an alliance of provincial-territorial governments and the federal government which negotiates drug prices collectively. Indeed, most provinces and territories now have programs which protect low-income individuals and families as well as anyone who pays an exceptionally large share of their income for prescription drugs. However, the recommendation to create a national formulary was not realized and this concept is still being discussed today.

LEGISLATIVE AND POLICY CONTEXT

Beyond the definition and history of pharmacare in Canada, at the IFSD we believe the context in which a policy is defined is also very important. And there are five documents that shape the current environment for a national pharmacare program: The *Constitution Act, 1867*, the *Canada Health Act*, the 2018 Report of the Standing Committee on Health (HESA) *Pharmacare Now: Prescription Medicine Coverage for All Canadians*, the most recent federal budget, Budget 2018, and the Discussion Paper from the federal Minsters of Health and Finance entitled *Towards Implementation of National Pharmacare*. It is by looking at these documents that the opportunity for a national pharmacare program in Canada becomes more apparent.

Constitution Act, 1867

The *Constitution Act, 1867* assigns authorities to Parliament in section 91 and to provincial legislatures in section 92. However, the explicit authority over the health of Canadians was never assigned to either level of government.[8] Within the *Constitution Act, 1867*, section 92(7 gives authority to provinces over all non-marine hospitals and psychiatric institutions. Since the *Constitution Act, 1867* gives taxing and spending powers to the federal government, the authority to transfer cash contributions with conditions attached to provinces and territories, as is the case under the *Canada Health Act*, is permitted.

As written in *Constitutional Jurisdiction Over Health and Health Care Services in Canada*, the authority over health and the authority over health spending are not one and the same[9]:

> *health is a matter of provincial jurisdiction, but [...] the federal government can make transfer payments to provinces for health care purposes and attach conditions to those transfers, even if they appear to invade provincial jurisdiction. Provinces agree to this only because they want to keep federal funding.* (p. 24)

The concept of constitutional authorities blends with spending agreements when it comes to social services such as health care. A common explanation for the rise in federal spending within provincial jurisdictions is the aftermath of the Great Depression, when Canadians desired guaranteed basic social services that are entrusted to the government.[10] At the time, provincial governments lacked the fiscal capacity to fund such services. But the federal government had taxation authorities enshrined in the *Constitution Act, 1867*, giving it greater ability to fund the services despite any jurisdictional disparities. This laid the groundwork for what became the *Canada Health Act*.

Canada Health Act

According to Section 3 of the *Canada Health Act*, "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." More specifically, the *Act* is the Canadian document that legislates the program principles, regulations, and various other details in order for provinces and territories to receive the cash contribution from the federal government to support their health care insurance plans.[11]

For a province or territory to qualify for the cash contribution from the federal government under the *Canada Health Act*, the health care insurance plan of the province or territory must satisfy the following five principles:

1. Public administration;
2. Comprehensiveness;
3. Universality;
4. Portability; and
5. Accessibility

The health care insurance plans for each province or territory must include hospital services, physician services, and surgical-dental services for all residents of that province or territory, with certain exceptions. These services must abide by the aforementioned five principles. Otherwise, the cash contribution can be reduced or entirely withheld.

Principle of Public Administration

Regarding the insured health services currently outlined under the *Canada Health Act*, the principle of public administration is the basis of the single-payer insurance model present in all provinces and territories.[12] This principle does not dictate ownership of agencies that deliver services but instead dictates that the insurance plan must be administered by a non-profit public authority. It "does not focus on the patient but is rather the means of achieving the ends to which the other four principles are directed."[13] It should be noted that the single-payer insurance model stems more from the health care insurance funding structure, which begins at the federal level and flows into provinces to provide health care, than from a specific point of principle.

Principle of Comprehensiveness

Section 9 of the *Canada Health Act* outlines the second principle, that of *comprehensiveness*, which also applies to the insurance plans of the provinces and territories. This principle requires that all insured health services be included under the coverage plans of the province or territory. The insured health services are determined on the basis of medical necessity. However, the decision lies with the provinces and territories to determine which services are considered medically necessary. And, as one can imagine, this determination is fraught with difficulties.[14] Simply put, the *Canada Health Act*

has the intention of "need, not want, dictating what the health care system provides".[15]

Principle of Universality

The principle of universality is one of the most commonly understood of the five principles. It ensures that all insured persons (residents minus members of the Canadian Forces, a person serving a prison term, or a person who has not lived in the relevant province for the minimum required time which cannot exceed three months are entitled to the insured health services covered by the province or territory according to a uniform set of terms and conditions. This principle ensures that everyone has access to the publicly-funded health services without discrimination within their province or territory of residence.

Principle of Portability

The principle of portability ensures that an insured person of a province or territory can maintain their coverage when travelling to other provinces and territories.[16] Provinces and territories have reciprocal billing agreements with each other to guarantee the rate of payment for insured health services provided within a different province or territory.[17] The rate of payment is that of the host province or territory (with the exception of Quebec, which pays its own rate to the host province or territory. These billing agreements ensure portability of the provincial health insurance, but they are not a requirement under the *Canada Health Act*, as demonstrated by Quebec. However, the inability to pay for the out-of-province/territory health service cannot be a barrier to accessing a medically necessary service.[18]

The second aspect of the principle of portability is the international coverage of a patient. The *Canada Health Act* requires that insured health services received outside of Canada will be reimbursed "on the basis of the amount that would have been paid by the province for similar services rendered in the province."[19] However, most provinces "limit the reimbursement of the cost of emergency health services obtained outside Canada under their public health care insurance."[20] As opposed to international emergency services, elective insured health services require the home province or territory to give prior consent.

Principle of Accessibility

The principle of accessibility is often cited alongside the Canadian health care system's principle of universality. To satisfy this principle, the provision of insured health services is not based on the ability of the insured person to pay. This guarantees that all Canadians have "reasonable access" to insured health services regardless of their financial situations.[21] However, this principle is not only intended to protect access to health care for those who cannot pay but has also been applied to timely access to health care.

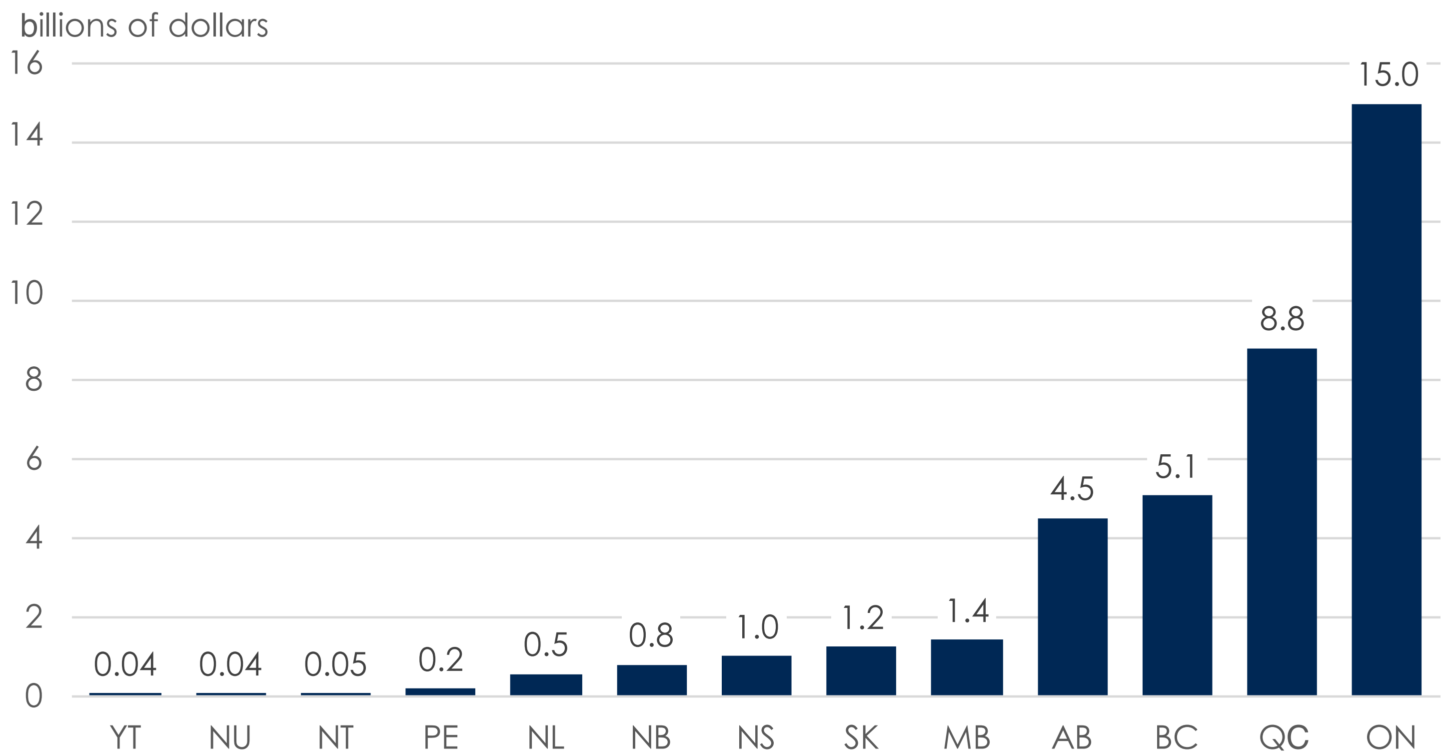
As with the previous three principles, accessibility is patient-oriented. However, problems arise with the definition of what "reasonable access" entails. To quote section 12 of the *Canada Health Act*, "the health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."[22] Barriers to reasonable access can include financial barriers, geographical barriers, and long wait times. Notably, whether the ability to pay should be able to mitigate the impediment to access posed by long wait times remains a source of debate in policy circles.

Federal Role under the *Canada Health Act*

Although the *Canada Health Act* is federal legislation, most references to the Government of Canada within it apply to provinces and territories receiving the cash contribution from the federal government. According to Section 5 of the *Act*, the Government of Canada will pay a full cash contribution through the Canada Health Transfer (CHT to provinces and territories that comply with the *Act*. The CHT is the largest major transfer to other levels of government.[23] It supports the provision of health care in all 13 provinces and territories, and is the tied to the fulfilment of the five principles that shape the *Canada Health Act*.

For the 2018-19 fiscal year, the CHT to all provinces and territories will total $38.6 billion and will be distributed to other levels of government on a per capita basis.[24] The most recent 2018-19 fiscal year transfer amounts are shown in Chart 1.[25]

Chart 1: Canada Health Transfers 2018-19



Source: Government of Canada

Should a province or territory not satisfy any of the five principles or the conditions of the cash contribution under the *Canada Health Act*, Section 15 of the *Act* allows the Governor in Council to reduce or withhold the cash contribution to that province/territory for the fiscal year. Take the context of the possible addition to the *Act* of the provision of prescription drugs to be included as an insured health service. If a province or territory does not provide insurance for prescription drugs, it would be violating the defining principles of the *Act* and therefore subject to a reduction or withholding of

the cash contribution. As will be discussed later, Budget 2018 suggests better incentivizing provinces and territories to correct any deviations from the *Act* in order to receive their full transfer.

Of course, the CHT is not the only transfer from the federal to provincial-territorial governments linked to health care. In Budget 2017, the federal government created a separate transfer linked to home care and mental health, which is subject to its own performance criteria. And as this was introduced outside of the *Canada Health Act*, it is not subject to the *Act* and the five principles contained therein.

FEDERAL BUDGET 2018

The Government of Canada's Budget 2018 proposed the creation of the Advisory Council on the Implementation of National Pharmacare. It is tasked with exploring options for a national pharmacare program that will aim to improve the accessibility and affordability of prescription drugs in Canada. The Advisory Council is headed by Dr. Eric Hoskins, a physician and former Minister of Health and Long-Term Care in the province of Ontario.

But Budget 2018 contained little detail on what a potential national pharmacare program might look like. Instead, comments made subsequently by federal Finance Minister Bill Morneau concerning the structure of the potential pharmacare program were much more informative. According to Minister Morneau's comments, a national pharmacare program will aim to fill in the coverage gaps in the current system rather than provide universal coverage for all Canadians. And, although these comments are not binding and should not restrict the actions of the government, they do suggest a national pharmacare program with this model would be unable to fall under the *Canada Health Act* in its current form as it would not satisfy the five principles of public administration, comprehensiveness, universality, portability, and accessibility.

Another interesting aspect of Budget 2018 is the section dedicated to better enforcement of the *Canada Health Act*. According to the Government of Canada in Budget 2018,

> *Under the* Canada Health Act*, the Minister of Health may direct deductions from Canada Health Transfer payments if a province or territory permits extra-billing and user fees in the delivery of public health care. To encourage provinces and territories to take corrective action to align their public health care systems with the principles of the* Canada Health Act*, as well as to recognize those that have addressed issues of non-compliance, the Government is proposing legislative amendments to allow Canada Health Transfer deductions to be reimbursed when provinces and territories have taken the steps necessary to eliminate extra-billing and user fees in the delivery of public health care.*

And while these deductions are uncommon, there are precedents for the federal government making them. Most recently, according to the *Canada Health Act* 2015-2016 Annual Report, "on the basis of their health ministry's report to Health Canada, a deduction in the amount of $204,145 was taken from the March 2016 Canada Health Transfer payments to British Columbia in respect of extra-billing and user charges for insured health services at private clinics in fiscal year 2013-2014."[26]

HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH REPORT: *PHARMACARE NOW*

Another defining document for the current pharmacare debate in Canada is the Report of the Standing

Committee on Health (HESA entitled *Pharmacare Now: Prescription Medicine Coverage for all Canadians*. The Committee's report contains 18 recommendations that aim to shape a national pharmacare program for Canadians. The first five recommendations focus on the expansion of the *Canada Health Act* to include prescription drugs; the next two recommendations discuss the development of a national formulary; the following eight recommendations outline issues around drug pricing and reimbursing; and the final three recommendations focus on data systems.[27]

The Committee's report evaluated the potential to include a pharmacare program under the *Canada Health Act* as an insured health service. The Committee writes "that the best way to move forward in establishing a universal single payer public prescription drug coverage program is by expanding the *Canada Health Act* to include prescription drugs dispensed outside of hospitals as an insured service under the *Act*." The Committee also quotes Dr. Marc-André Gagnon, Professor at Carleton University's School of Public Policy and Administration, who said that a drug coverage system that only addresses the current gaps in coverage is "based on the commercial needs of the private plans, not the health needs of Canadians."[28]

In the context of expanding the *Canada Health Act* to include prescription drugs as an insured health service, the Committee's report recommends that the CHT receives additional funding for the provinces and territories to account for the costs of the inclusion of public prescription drug costs. This recommendation ensures cost-sharing of a national pharmacare program between the federal and provincial-territorial governments.

However, this aspect of the Committee's report creates some questions. For instance, what if amendments are made to the *Canada Health Act* and the threat of a reduced CHT was to arise at some future date for reasons outlined in Section 15 of the *Act*? Would the federal government exert this power and withhold or reduce the CHT if a province or territory does not provide drug coverage aligned with the *Act*? Alternatively, consider if a new government is elected in the future and it does not support federal funding for pharmaceutical coverage within the *Act* through the CHT and chooses to withdraw that funding: under that circumstance, will provinces and territories still be required by the *Act* to provide drug coverage to all insured people in order to receive the CHT?

These are important questions to consider when building a national pharmacare program under the *Canada Health Act* and using the CHT to fund it. Amending the *Act* would not be easy. According to Dr. Steve Morgan, Professor at the School of Population and Public Health at the University of British Columbia, in his testimony to HESA, although it is possible to include pharmacare through the *Act,* it would require some amendments.[29]

However, a national pharmacare program does not need to abide by the *Canada Health Act* or be funded through the CHT. Instead, entirely new legislation and policies can be created for the implementation of prescription drug coverage in Canada. Dr. Steve Morgan, once again, has recommended a separate act for drug coverage that would contain specific details regarding how this program would run.[30]

And, indeed, as was mentioned in the discussion of the CHT, there is a recent precedent for a separate funding structure. In December 2016, the federal government confirmed that future annual increases in the CHT would be the greater of the 3-year moving average of nominal GDP growth or 3%, as opposed to the prior 6% annual pace or the 5.2% requested by the provinces and territories at that time. In the face of rising cost pressures linked to an aging population, provincial-territorial

governments were rightly displeased to know the federal share of health funding would further decline over time. So, to sweeten the deal, the federal government committed to provide funding specifically for home care and mental health, albeit a small fraction of the additional funding requested by the provinces and territories (Department of Finance, 2017). This new transfer would also come with strings attached, in the form of "performance indicators and mechanisms for annual reporting" (per Budget 2017). This culminated in A Common Statement of Principles on Shared Health Priorities, where federal-provincial-territorial Health Ministers agreed "that the collection and public reporting of outcomes is key to enabling Canadians to assess progress on health system priorities," among other commitments.

DISCUSSION PAPER FROM THE FEDERAL MINISTERS OF HEALTH AND FINANCE

In June 2018, the federal Minister of Health and Minister of Finance published a discussion paper entitled Towards Implementation of National Pharmacare. According to the message from the Ministers, "this discussion paper is designed to provide a starting point for the Council's dialogue with Canadians about the implementation of national pharmacare in Canada. The paper provides an overview of the current system and its challenges, and identifies key objectives and questions to frame the work of the Council and support a focused dialogue."

The discussion paper outlines a series of questions related to what the federal government believes are the key issues to be considered about national pharmacare. These questions include:

- Who should be covered under national pharmacare?
- How should national pharmacare be delivered?
- Which drugs should be covered as part of a national pharmacare plan?
- How much variability across different drug plans or jurisdictions should there be in the list of drugs covered by national pharmacare?
- Should patients pay a portion of the cost of prescription drugs at the pharmacy?
- Should employers, which currently play a significant role in funding drug coverage for their employees, continue to do so (either through contributions to a private plan or through a public plan)?

It should be noted that the discussion paper does not assume that the *Canada Health Act* will be the foundational document for a national pharmacare plan. Indeed, it does not pose any questions related to amending the *Act* to include pharmacare.

SUMMARY

In summary, the federal and provincial-territorial governments must work within the jurisdictional constraints laid out in the *Constitution Act, 1867*. But, in doing so, many options remain available for the federal government to introduce a national pharmacare program.

Specifically, the decision comes down to whether the *Canada Health Act* should be amended to include pharmacare as an insured health service. This would require that a national pharmacare program follow the five principles previously discussed – public administration, comprehensiveness, universality, portability, and accessibility. At the same time, including pharmacare as an insured health service under the *Act* could give greater flexibility to provincial-territorial governments to determine the design of a national pharmacare plan within their own borders.

DIFFERENCES IN DRUG PROGRAMS IN CANADA

The range of drug plans offered within Canada is quite broad, with no province or territory the same as another, let alone the federal government. For instance, each province or territory offers a different formulary. And within each jurisdiction, different subgroups of the population qualify to receive these drugs based on different circumstances related to socioeconomic status, age, disability status, etc. Some groups are also required to provide some cost-sharing in the form of a copayment or deductible, while other groups are not. Still other groups do not receive any pharmaceutical cost support at all outside of hospitals. This group – often those people who are self-employed, who work part time, or who ork in precarious employment – also differs greatly across Canada.[31]

This assortment of programs from coast to coast to coast provides compelling evidence of inefficiencies that could be addressed by a national pharmacare program. But any national pharmacare program that is not universal would have to weave its way through all of these various federal-provincial-territorial programs that have different cost-sharing mechanisms and target different populations. As such, a targeted approach to delivering a national pharmacare plan could create more administrative problems than it is worth.

COMPARING GROUPS SERVED UNDER PROVINCIAL-TERRITORIAL DRUG PLANS ACROSS CANADA

All provinces and territories have their own public drug coverage environment. Generally, there are programs that target certain populations that may require assistance with paying for prescription medications. Table 1 outlines the various populations in each province and territory that receive some publicly provided financial support for drug coverage (more detailed information is provided in Annex 1).

TABLE 1: COMMON TARGET GROUPS RECEIVING PRESCRIPTION DRUG COVERAGE IN CANADA

Jurisdiction	General Population	Children	Seniors	Low Income	Military & Veterans	RCMP	First Nations
BC	YES	YES	YES	YES	NO	NO	YES
AB	YES	YES	YES	YES	NO	NO	NO
SK	NO	YES	YES	YES	NO	NO	NO
MB	YES	YES	YES	YES	NO	NO	NO
ON	NO	YES	YES	YES	NO	NO	NO
QC	YES	YES	YES	YES	NO	NO	NO
NB	YES	SOME	YES	YES	NO	NO	NO
NS	YES	YES	YES	YES	NO	NO	NO
PE	COMBO OF PLANS	COMBO OF PLANS	YES	YES	NO	NO	NO
NL	NO	NO	YES	YES	NO	NO	NO
NT	SPECIFIED DISEASES	NO	YES	NO	NO	NO	YES
YK	CHRONIC ILLNESS	NO	YES	NO	NO	NO	NO
NU	CHRONIC ILLNESS	NO	YES	NO	NO	NO	NO
FED	NO	NO	NO	NO	YES	YES	YES

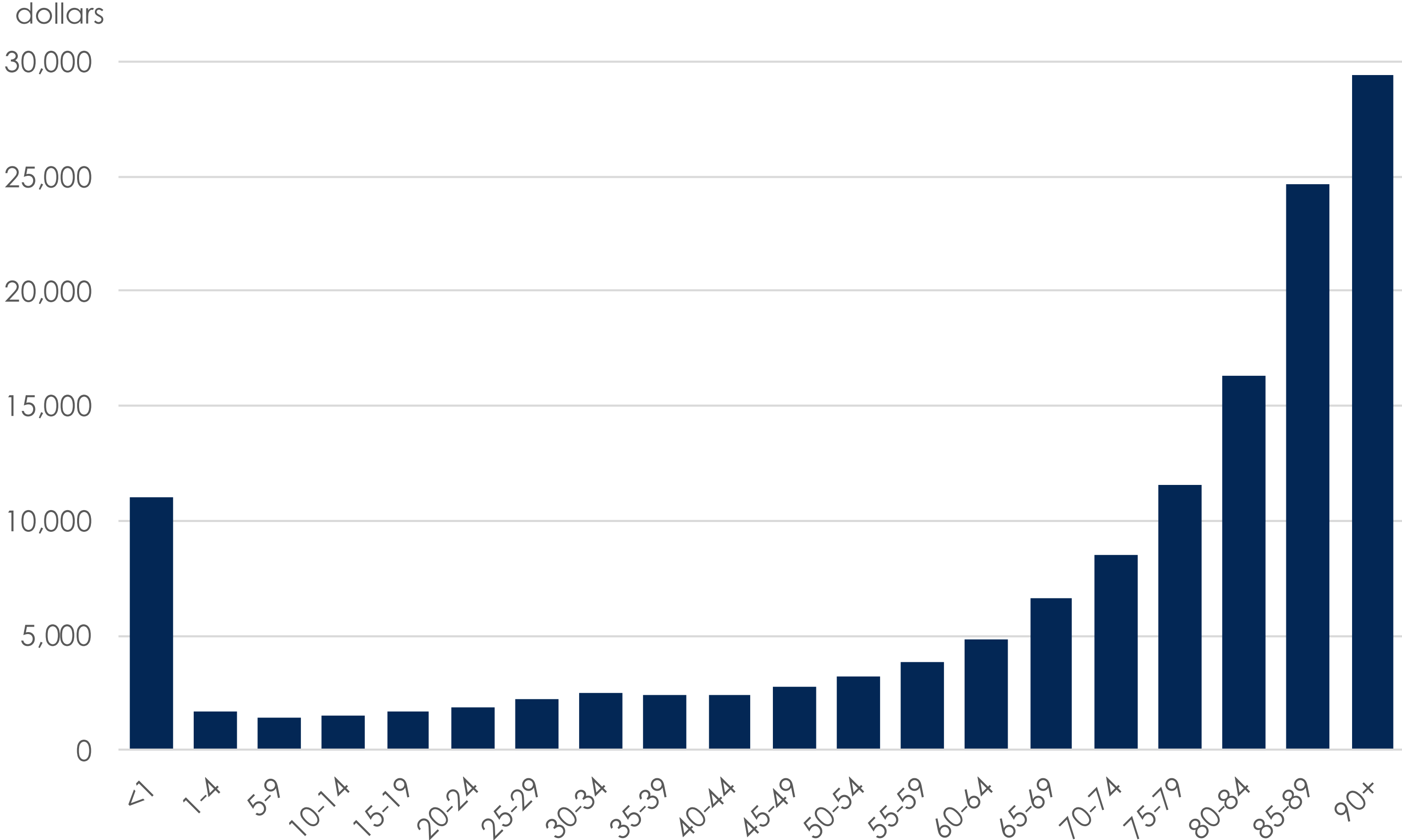
Source: Respective Provinces Ministries of Health and Clement et al. (2016) Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts.
Notes: "No" signifies that there is not a targeted program specifically for that population. For more details, refer to Annex 1.

Starting from the subnational jurisdiction that offers the broadest drug coverage, Quebec requires all residents to be covered. Therefore, if an individual or family does not have access to private insurance, the public drug insurance plan is applied to them. This makes Quebec the only province to ensure that everyone has drug coverage. In contrast, most other provinces have targeted programs which focus on certain populations. An extreme example of a targeted system is that of Prince Edward Island, where there are several programs which target very specific groups including low-income people, people with Hepatitis, Cystic Fibrosis, or Diabetes as well as people in nursing homes.

Some provinces also have income-based programs, like British Columbia, where anyone can register for “Fair Pharmacare” and receive coverage that is tied to income brackets. Another plan to take note of is that of New Brunswick, where there is one plan with various premiums based on incomes as well as multiple targeted plans for more vulnerable populations such as seniors and people with HIV/AIDS.

Regardless of the specific provincial-territorial plan, a subgroup which receives government support for purchasing pharmaceuticals is seniors. This makes a great deal of sense, given that an individual’s income tends to be lower in the later years of life while the cost of providing health care rises nearly exponentially after about 50 years of age (Chart 2).

Chart 2: Per Capita Health Spending in Canada by Age



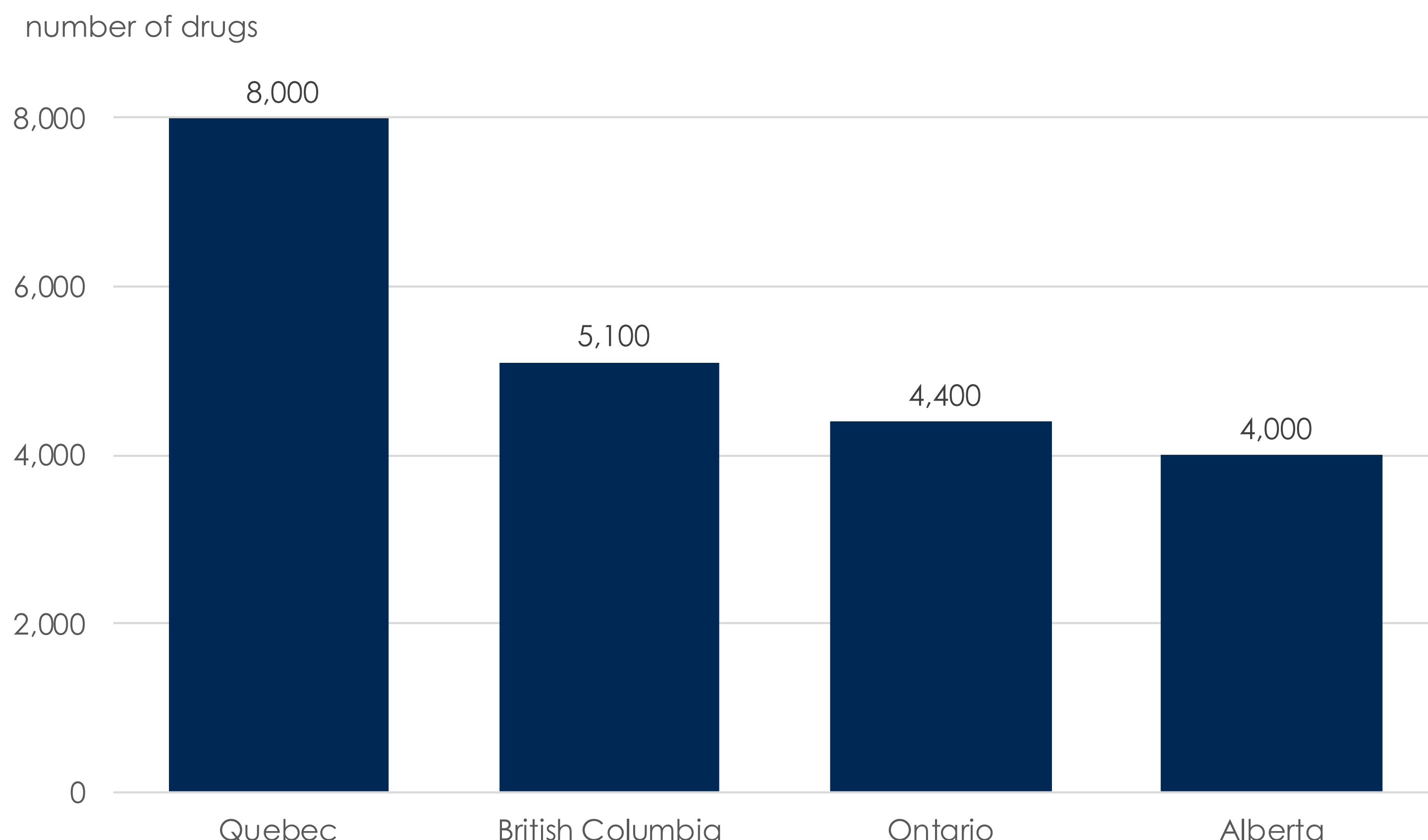
Source: Canadian Institute for Health Information.
Note: Estimates are for 2015.

CURRENT PROVINCIAL-TERRITORIAL FORMULARIES

Building on the concepts defined earlier, this section of the report will examine the various formularies that currently exist across Canada. These formularies are more comprehensive than either an essential-medicines or most-frequently-prescribed-drugs formulary, which will be explored in more detail later.

To begin, Quebec offers the most comprehensive formulary among Canadian provinces, covering over 8,000 unique drugs. The Quebec formulary was subsequently used by the PBO (2017a), which costed a national pharmacare program at the request of HESA. This stands in contrast to the formularies of the three other largest provinces in Canada, whose formularies range from 4,000 to 5,100 drugs (Chart 3). However, many of these drugs contain the same active ingredient, or vary only in strength or brand name. Meanwhile, some provinces define their formularies by drug name or chemical family, which can lead to larger or smaller formularies depending on how this is done, and can therefore complicate the comparability of formularies across Canada.

Chart 3: Selected 2017 Provincial Formularies in Canada

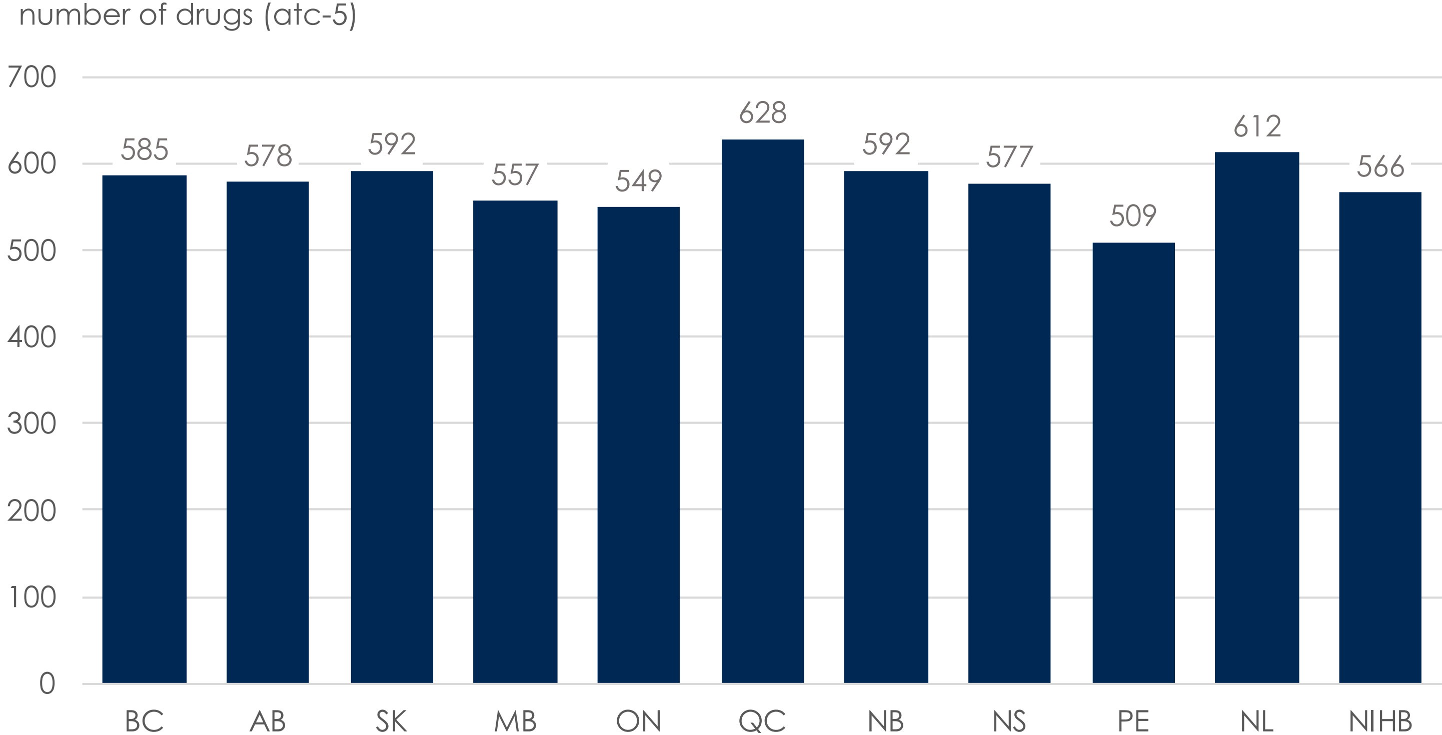


Sources: Various official provincial sources.
Note: Different sources define their formularies by drug name, chemical family, or otherwise, which can lead to a larger or smaller drug formulary despite providing coverage for the same drugs.

In an attempt to correct for this problem, the Patented Medicine Prices Review Board (PMPRB) conducted research on the comprehensiveness of the various public formularies (PMPRB, 2017).[32] Chart 4 outlines a review of public formularies for 729 drugs with different classifications based on the

organ or system on which they act and according to their chemical, pharmacological, and therapeutic properties.[33] These 729 drugs represented 82% of total drug costs in Canada in 2015. Chart 4 shows Quebec with the most comprehensive formulary when drugs are classified in this manner, with 89% of the 729 drugs covered. Meanwhile, Prince Edward Island's formulary is the least comprehensive but still covers 70% of the 729 drugs. As such, what is clear is that drug coverage could be characterized as comprehensive across Canada as the bulk of the most widely used drugs are offered under the different federal-provincial-territorial formularies.

Chart 4: Drug Coverage of Canadian Formularies



Source: Patented Medicine Prices Review Board (PMPRB).
Notes: PMPRB analysis using CIHI's NPDUIS Database calculated the number of drugs using the ATC-5 classification. As such, several unique drugs with the same active ingredient are lumped together to represent one drug. There are 1,456 drugs listed on at least one publicly-funded formulary in Canada. For this study, the PMPRB selected 729 drugs, representing 82.6% of total drug costs. Drugs for specialized programs or with limited data were excluded from the study.

It should also be noted that certain public drug coverage programs offer a variety of formularies within the same jurisdiction. Depending on which program an individual is covered by, they may follow a different formulary than another program in the same province or territory. Many provinces and territories clearly identify which programs cover which different drugs included on the formulary.

CLEAN Meds List OF ESSENTIAL MEDICINES

As discussed earlier, the WHO broadly defines essential medicines as "those (medicines) that meet the priority health care needs of the population". A majority of WHO countries, 117 of 204, have implemented an essentially medicines list.[34] However, Canada does not have an implemented essential medicines list and, as a result, Canadians covered by federal or provincial-territorial drug

programs are not guaranteed access to essential medicines.[35]

The list of essential medicines used in Canada is the CLEAN Meds list, which is an adaptation of the WHO's list of essential medicines. The list includes medicines for the following therapeutic areas: anti-HIV, anti-infective, antiallergic and anaphylaxis, anticonvulsive, antimigraine, antineoplastic and immunosuppressive, antiparkinsonism, blood, cardiovascular, dermatological, diuretic, eye preparation, gastrointestinal, hormonal and endocrine, joints diseases, mental and behavioural disorders, pain and palliative care, respiratory tract, and some vitamins and minerals as well as two unclassified medicines.

The 13 provinces and territories each have the authority over all decisions concerning prescription drug coverage in their respective jurisdictions, in accordance with the *Canada Health Act*. Every province and territory has some form of public drug coverage which follows a formulary that determines which pharmaceuticals are covered by public plans. To assess the feasibility of implementing an essential medicines list in Canada, the IFSD compared the 128 adult essential medicines on the CLEAN Meds list to all the federal, provincial, and territorial public drug coverage program formularies in Table 2 (a more detailed breakdown can be found in Annex 2).

TABLE 2: CLEAN Meds List vs. PROVINCIAL AND TERRITORIAL FORMULARIES

	Drugs Provided	In Combination Only	Special Authorization Required	Not Provided
NIHB	113	3	10	2
NT	113	3	10	2
NU	113	3	10	2
QC	104	0	17	7
NL	107	0	13	8
BC	102	0	17	9
NB	101	3	15	9
ON	93	0	23	12
AB	97	3	15	13
SK	95	1	19	13
PE	94	2	19	13
YK	101	1	12	14
NS	90	1	17	20
MB	88	0	8	32

Source: St Michael's Hospital, compiled by the Institute of Fiscal Studies and Democracy.
Notes: All provincial and territorial formularies by the respective health ministries; Federal Non-Insured Health Benefits formulary.

Both the Northwest Territories and Nunavut use the Non-Insured Health Benefits (NIHB) formulary, which is a federally-made list for the drug coverage provided for registered First Nations and recognized Inuit people. This formulary covers 113 of the 128 essential drugs without any special authorization required and a further 10 essential drugs requiring special authorization, called a

"limited use benefit" in this formulary. The NIHB lacks two of the adult essential medicines, Bevacizumab and Eletriptan, which are common exclusions across most other provincial and territorial formularies. Only Yukon's formulary covered Bevacizumab for two of its public drug coverage programs but it requires special authorization. Only Quebec's formulary covered Eletriptan. The NIHB formulary covers the most essential medicines out of all the formularies in Canada, giving the Northwest Territories and Nunavut the most comprehensive coverage for essential medicines according to the CLEAN Meds list.

Quebec, notably the only province or territory with a universal pharmacare system, ranks well among all regions, lacking only 7 of the 128 essential medicines. This puts the Quebec formulary right behind the federal formulary used in the Northwest Territories and Nunavut. Meanwhile, Manitoba's formulary had the least in common with the CLEAN Meds list, as only 88 of the 128 essential medicines are covered completely with eight more requiring a special authorization. In total, 59 out of the 128 essential medicines are covered in every formulary and no single drug is excluded from coverage in every formulary.

The variance in coverage across Canada is quite broad, even when only considering the CLEAN Meds list of essential medicines. The NIHB formulary is quite different from the Manitoba formulary, and even the formularies in between vary according to which medicines require special authorization in order to be covered. For example, only the British Columbia formulary has a special authorization requirement on Gliclazide, a medication for type 2 diabetes mellitus, while all other formularies cover it without needing special authorization.

Further, the "In Combination Only" category represents essential medicines which are covered in a formulary but only in combination with one or more other medicines. For example, Emtricitabine is often covered in combination with Tenofovir, another essential medicine. Quebec is the only province which covers Emtricitabine without having to be in combination with another drug and 4 provinces do not cover it at all.

FEDERAL DRUG PROGRAMS IN CANADA

The Government of Canada provides prescription drug coverage for about one million Canadians who are members of eligible groups. These groups include First Nations and Inuit, members of the Canadian Forces, Veterans, members of the RCMP, and inmates in federal penitentiaries. Depending on the program, the federal government may or may not be the actual provider, but it is always the funder. For instance, drug coverage for members of the Canadian Forces is provided by Blue Cross, a private insurance company. For registered First Nations people and recognized Inuit, however, the federal government is the provider and funder of drug coverage.

This information will be useful when developing a national pharmacare plan, specifically when discussing the use of a federal transfer to provinces to provide drug coverage. This is because some residents of the various provinces and territories are covered by federal plans already and a per capita transfer would, effectively, be funding people who already receive federal coverage. As these designated groups are provided coverage for pharmaceuticals by the federal government, it is possible that they would not be included among the population that is eligible for a provincial-territorial drug coverage per capita cash transfer.

First Nations and Inuit Non-Insured Health Benefits (NIHB)

This program is administered by the Indigenous Services Canada's First Nations and Inuit Health Branch. An eligible client must be a resident of Canada and be a First Nations person who is registered under the Indian Act (820,120), an Inuk recognized by an Inuit land claim organization (65,030), or a child less than 18 months old whose parent is a registered First Nations person or a recognized Inuk. Table 3 demonstrates the share of Treaty Indians and Inuit in each province.

TABLE 3: TREATY INDIAN AND REGISTERED INUIT POPULATIONS (in 000s)

	Registered or Treaty Indian	Inuit	Total Population	% of Population
ON	171	3.9	13,448	1.30
MB	127	0.6	1,278	10.00
SK	110	0.4	1,098	10.08
AB	123	2.5	4,067	3.09
BC	136	1.6	4,648	2.96
QC	77	14	8,164	1.12
NB	14	0.4	747	1.97
NS	19	0.8	924	2.14
PE	1.2	0.1	143	0.89
NL	21	6.5	520	5.31
NT	13	4.1	42	41.74
YK	5.9	0.2	36	17.12
NU	0.2	30	36	84.30
CAN	820	65	35,152	2.52

Sources: CANSIM, 2016 Census.

The benefits provided by the federal government under the NIHB include: drugs and pharmacy products, dental care, vision care, medical supplies and equipment, medical transportation, and mental health counselling. The program covers prescription and over-the-counter medications that are included on the NIHB drug benefit list, including benefits that are: 1) open, which do not require prior approval, 2) limited use, which may be eligible for coverage if the criteria for coverage are met, and 3) prescribed by an NIHB recognized health professional, such as a physician. Additionally, exception status drugs are not listed in the drug benefit list but may be approved in special circumstances.

Health Benefits for the Canadian Armed Forces

This program is administered through the Department of National Defence and the plan is provided by Blue Cross.[36] All Regular Force personnel are covered from the time of enrolment to the effective date of release from the Canadian Armed Forces (CAF). Reserve Force personnel are covered only during specified periods of eligibility based on their duty status and the relatedness of their illness or injury to military service.

CAF members are provided comprehensive coverage, whether serving in Canada or abroad, including:

hospitalization and physician services, supplemental health benefits, drugs and health practitioner's benefits, occupational health services, dental services, and mental health resources. The Canadian Armed Forces Drug Benefit List describes those medications that have been determined appropriate for public funding and subsequent provision to Canadian Armed Forces personnel.

Health Care Benefits for Veterans

This program is administered through Veterans Affairs Canada (VAC) and is provided by Blue Cross.[37] To become eligible to qualify to receive financial support for treatment benefits, a person must be: in receipt of a disability benefit, in receipt of services through the Veterans Independence Program, in receipt of financial assistance through the Long-Term Care program, or in receipt of the War Veterans Allowance.

There are 14 health-care programs of choice available to veterans, including: aids for daily living, ambulance services, audio (hearing) services, dental services, hospital service, medical services, medical supplies, nursing services, oxygen therapy, prosthetics and orthotics, related health services, special equipment, vision (eye) care, and prescription drugs. Under the prescription drugs program, Veterans Affairs Canada provides coverage for drug products and other pharmaceutical benefits to those who have demonstrated a medical need and have a prescription from an authorized health professional. Standard benefits and special authorization benefits are included in this program. The specific medicines covered are listed on the VAC Drug Formulary.

Royal Canadian Mounted Police (RCMP) Supplemental Health and Dental Care Benefits

Supplemental health and dental care benefits for serving Regular Members are provided for non-work-related illness or injury and are administered by the RCMP's claims administrator in accordance with RCMP policies. These benefits are provided at no cost to the member on an as-needed basis, with limitations relating to the maximum dollar coverage, frequency restrictions, and preauthorization requirements.

The RCMP Supplemental Health Care benefits for serving Regular Members cover services such as psychotherapeutic services, prescription drugs, dental services, vision and hearing care, physiotherapy, aids to daily living, and others.

Health Services for Inmates in Federal Penitentiaries

In Canada, on an average day, there are around 15,000 adults in federal custody. Correctional Service Canada (CSC) is legally mandated to provide health services to federal offenders. The *Corrections and Conditional Release Act* indicates that CSC is responsible for providing "every inmate with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration in the community."

However, according to experts in the prison health care system, federal inmates receive substandard health care that varies widely across the correctional system. This violates CSC's own rules. According to Howard Sapers, the correctional investigator for Canada, the biggest complaint that his office has received for the last decade is the inequality of health care and access to health care in federal penitentiaries across Canada.[38]

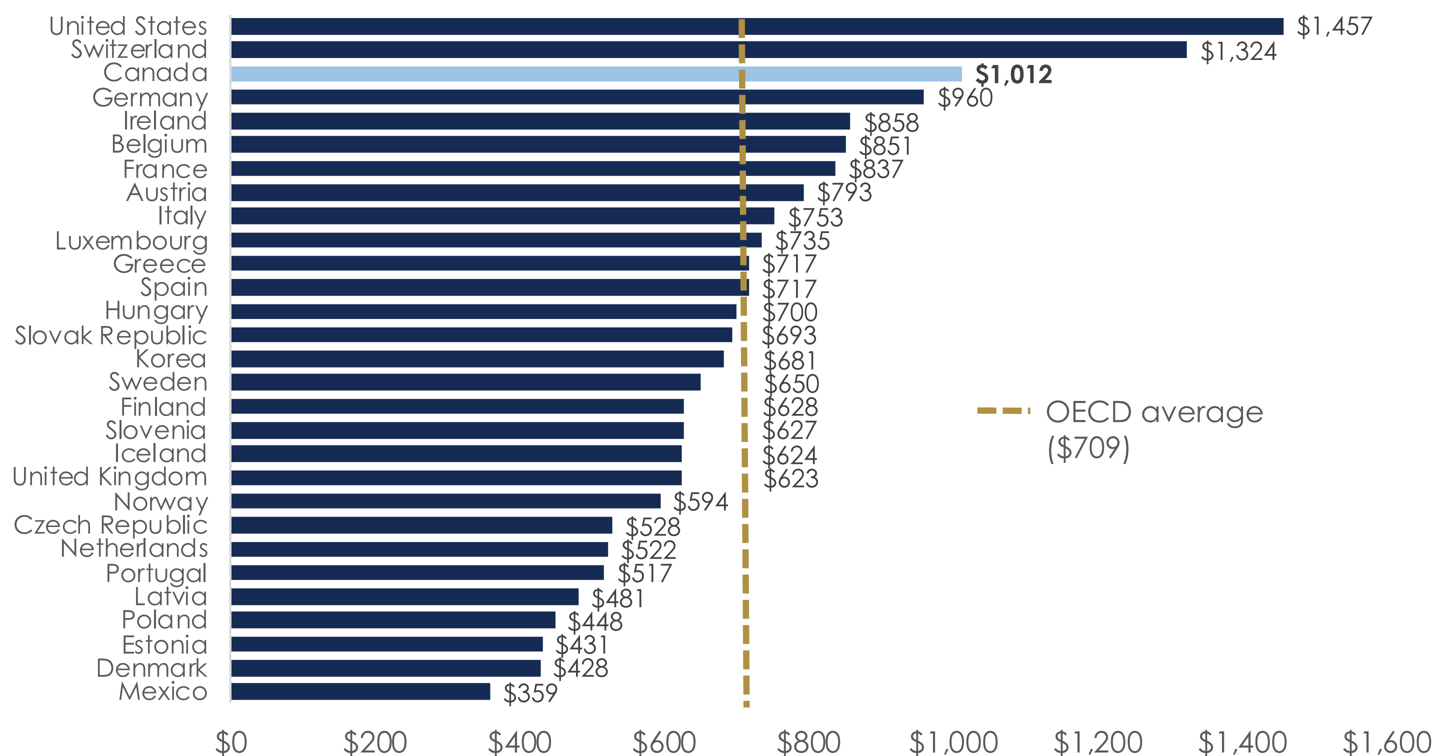
CANADIAN DRUG SPENDING IN AN INTERNATIONAL CONTEXT

While the domestic context for a national pharmacare plan is important, it is equally necessary to observe the lessons learned in other countries that have implemented similar programs. Indeed, “Unlike most member countries of the Organisation for Economic Co-operation and Development (OECD), Canada does not have a national pharmacare program – that is, a single system of public insurance coverage for prescription drugs.” (HESA, 2018) As such, there is a real opportunity for the federal government to avoid the pitfalls encountered by other jurisdictions while benefiting from past positive outcomes.

How Canadian Drug Spending Compares Internationally

Canadians spend a lot on pharmaceutical drugs. Drawing on analysis published by the Canadian Institute for Health Information (CIHI) using data from the Organization for Economic Co-operation and Development (OECD), one can observe that Canada had the third highest per capita expenditure on drugs in the OECD in 2015, after the United States and Switzerland (Chart 5). Indeed, in 2015, Canadians paid an average of over 40% more per capita on pharmaceutical drugs than the OECD average.

Chart 5: Total Expenditure on Drugs Per Capita in 2015



Sources: Organization for Economic Co-operation and Development. OECD Health Statistics 2017. Originally published by the Canadian Institute for Health Information (CIHI), Drug Spending at a Glance, 2017.
Notes: Includes pharmaceutical goods and other medical non-durables. These are OECD countries for which data was reported in 2015.

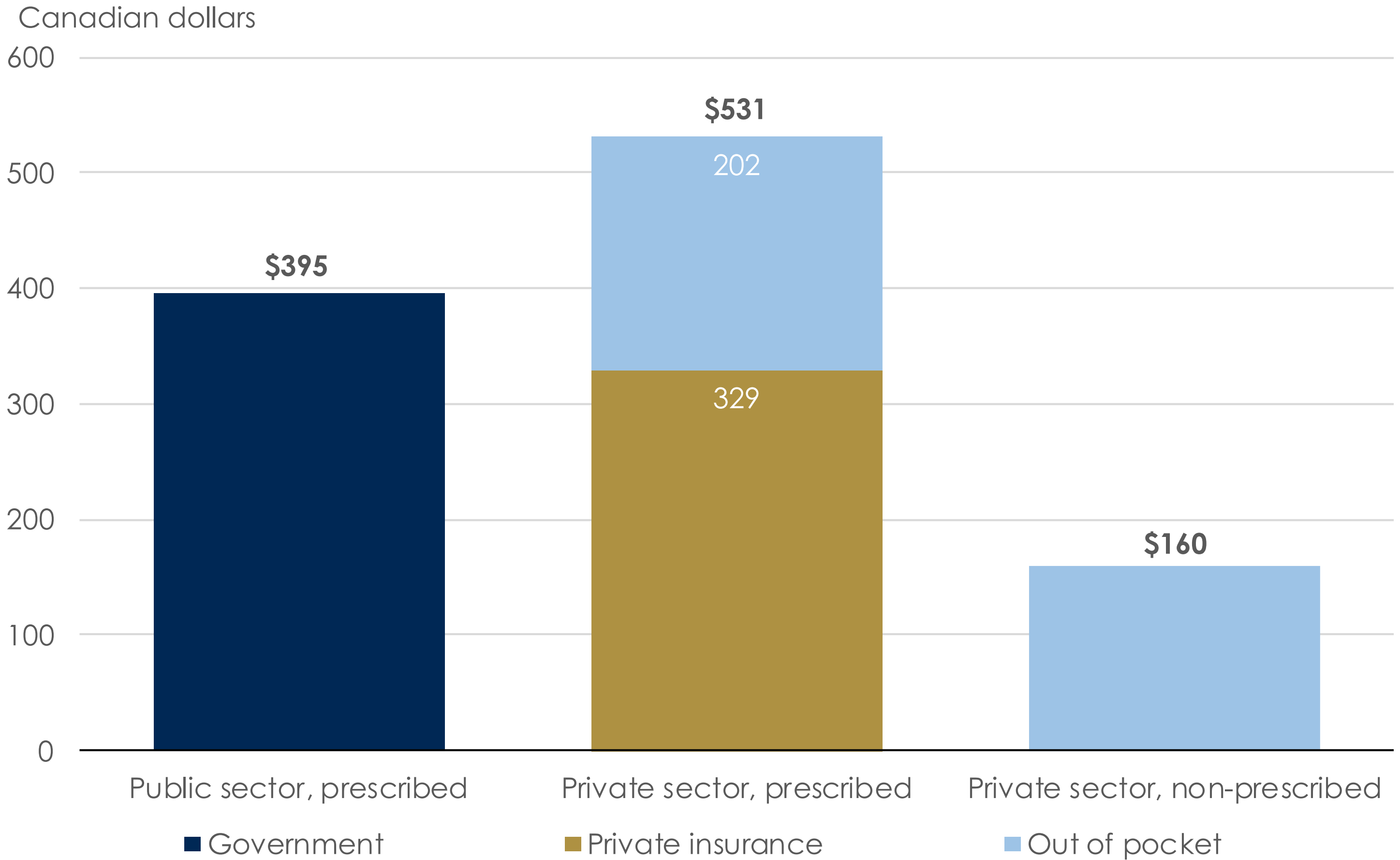
This difference matters a great deal, as the Patented Medicine Prices Review Board –the organization which sets the maximum prices for brand-name drugs across Canada – is modifying its list of comparator countries it looks at as of January 1, 2019. Currently, the PMPRB sets the maximum prices that can be charged in Canada (known as list prices) at the median price from a list of seven countries. This list of countries, known as the PMPRB7, include the United States, the United Kingdom, France, Germany, Switzerland, Italy, and Sweden. As a consequence of using these countries as comparators,

> *Canada pays the third highest prices for patented medication in the world […] The new regulations would change that list to 12: Australia, Belgium, France, Germany, Italy, Japan, the Netherlands, Norway, South Korea, Spain, Sweden, and the United Kingdom. Notably missing are the U.S. and Switzerland, both of which are currently included in the seven, and both of which pay the highest prices for their drugs. Those two were dropped, Health Canada says, because the U.S. does not have a consumer protection mandate, and Switzerland has a higher national per capita income than Canada […] That change is expected to lower prices across the board […] That has the potential for large savings, as the OECD median price for patented medicine is 22 percent below Canada's. In an email to Healthy Debate, Health Canada said that it expected changing the comparator countries would lower expenditures on patented drugs by five percent, which would equal $4.3 billion over 10 years.*

This follows a reduction in the price of generic drugs by 25% to 40% for provincial/public drug plans, announced in January 2019 by the pan-Canadian Pharmaceutical Alliance, as part of an agreement reached by participating federal, provincial, and territorial public drug plans and the Canadian Generic Pharmaceutical Association. (CBC News, 2018)

Lowering the cost of patented medicines will go a long way to supporting those Canadians that pay a large portion of their health care costs out-of-pocket. Again, looking to analysis by the CIHI (2017), it can be observed that the bulk of drug spending per capita in Canada is paid for privately, be it for prescribed or non-prescribed drugs, with out-of-pocket expenses making up about a third of total drug spending (Chart 6). That said, drug expenditures per capita by Canadian governments also make up around one third of total per capita spending on pharmaceuticals.

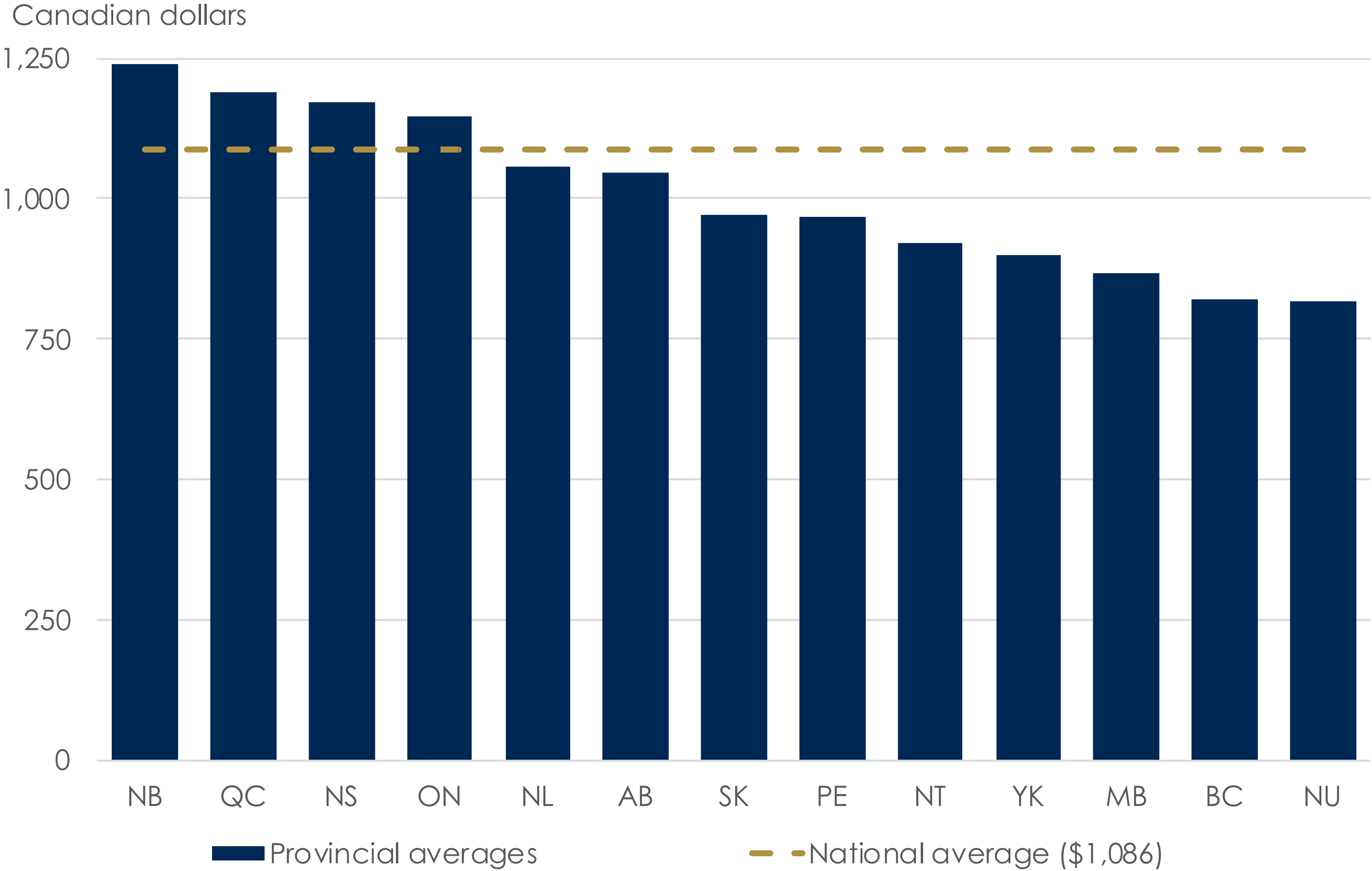
Chart 6: Canadian Drug Spending per Capita by Source



Source: Canadian Institute for Health Information.
Note: The data presented here are for 2017.

Of course, drug expenditures per capita in Canada differ greatly across provinces (Chart 7). For instance, in 2017, New Brunswick spent over $1,200 annually per capita, just slightly higher than Quebec, Nova Scotia, and Ontario. Meanwhile, Nunavut and British Columbia spent just barely more than $800 per person in that same year. These numbers include both public and private expenditures, which again differ markedly across Canadian provinces.

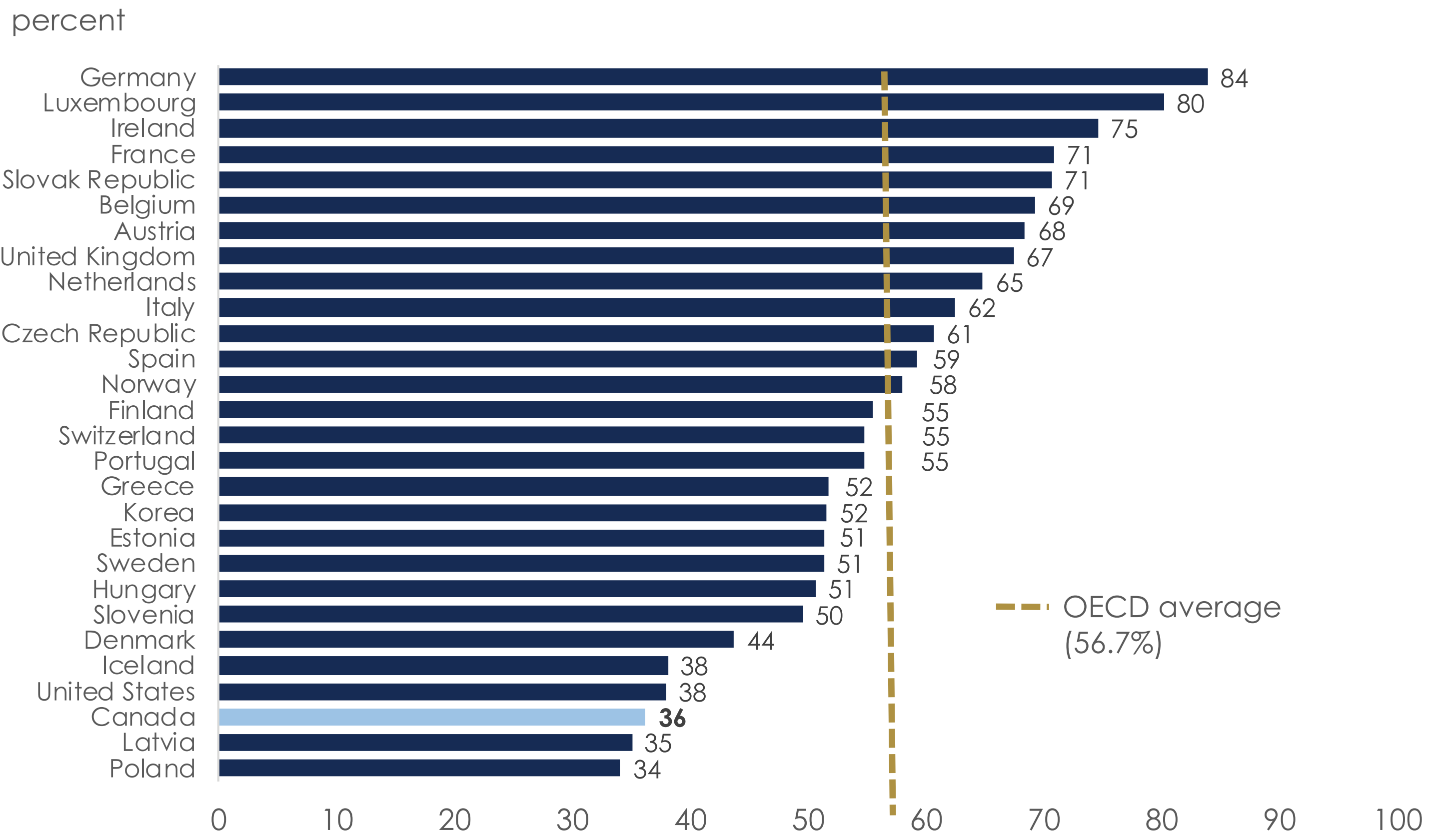
Chart 7: Canadian Drug Expenditures Per Capita, 2017



Source: Canadian Institute for Health Information.

As the CIHI (2017) also noted, the public share of drug spending in 2015 greatly varied across OECD countries, “ranging from 34% in Poland to 84% in Germany. Canada, with a public share of 36%, was among the countries with the lowest shares.” Chart 8 illustrates Canada’s public share of drug spending in the context of 27 other OECD countries. This is well below the 56.7% average public share of drug spending among the comparator countries. The CIHI also noted the public share of drug spending in Canada has remained broadly stable over time, meaning this low relative share is not a short-term phenomenon.

Chart 8: Public Share of Total Drug Expenditures in 2015



Sources: Organization for Economic Co-operation and Development. OECD Health Statistics 2017. Based on data assembled by the Canadian Institute for Health Information (CIHI).
Note: Excludes pharmaceutical consuption in hospitals.

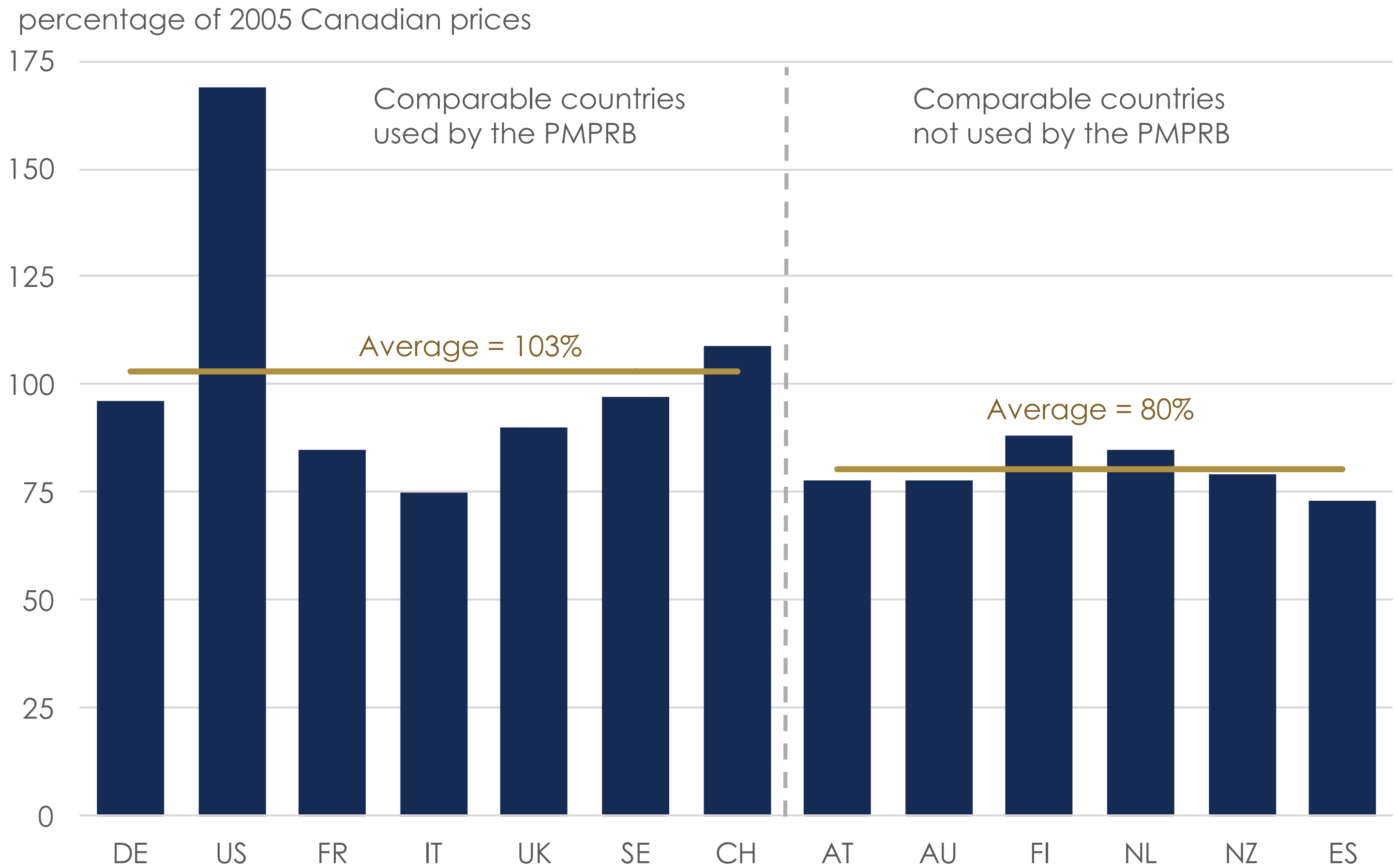
A noteworthy omission from this list of countries is New Zealand, which has a very aggressive drug pricing regime (the details of which will be discussed below). In 2007, the last year for which the OECD published data on expenditures on pharmaceuticals for New Zealand, this small country's per capita spending on drugs was equivalent to CN$310 (OECD Health Statistics, 2017; IMF WEO Database, 2018). This was the second lowest cost in the OECD at the time, after Estonia, and was less than 40% of the cost paid by Canadians that year. Meanwhile, the average American resident paid nearly four times as much for pharmaceuticals as a New Zealand resident in 2007 (in Canadian dollars).

Pharmacare Models Around the World

New Zealand

The low cost of pharmaceuticals in New Zealand requires some further explanation. "In 1993, New Zealand created the Pharmaceutical Management Agency (PHARMAC), which looks at effectiveness, suitability and cost to decide what's covered by the government and negotiates prices on behalf of the entire country. By tightly controlling the country's formulary, it has been able to keep costs flat while drug use has risen. One study found that New Zealand paid 51% less than British Columbia for four large, established classes of prescription drugs" (Healthy Debate, 2015). Indeed, according to Gagnon (2010), average patented drug prices in New Zealand were 79% of the average of Canadian prices in 2005 (Chart 9a).

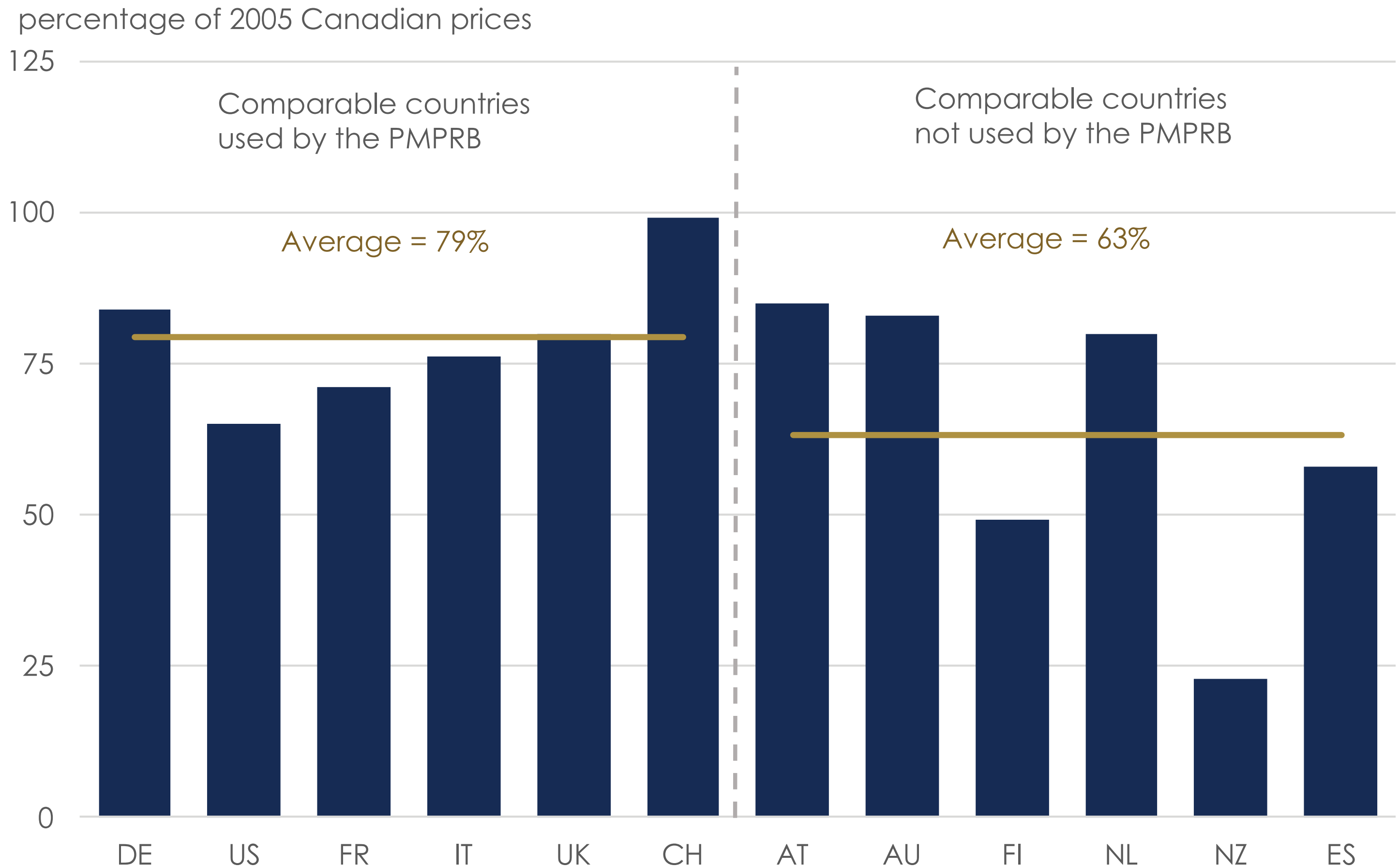
Chart 9a: Countries' Average Patented Drug Prices



Source: Marc-Andre Gagnon (2010), The Economic Case for Universal Pharmacare.
Note: The PMPRB refers to the Patented Medicine Prices Review Board.

Where New Zealand pays lower prices for patented drugs than Canada, the price it paid was not out of line with Australian and Austria in 2005 and was higher than Italy and Spain. However, New Zealand really sets the bar in terms of pricing for generic drugs. In 2005, the cost of generic drugs in New Zealand was 23% of the price paid in Canada (Chart 9b). In fact, Canada paid the highest price of all comparator countries examined by Gagnon (2010). This reinforces the importance of price negotiations undertaken with generic drug producers in early 2018 (CBC News, 2018).

Chart 9b: Countries' Average Generic Drug Prices



Source: Marc-Andre Gagnon (2010), The Economic Case for Universal Pharmacare.
Note: The PMPRB refers to the Patented Medicine Prices Review Board.

New Zealand stands out as a country with highly controlled pharmaceutical spending growth thanks to its single-payer public financing system that is integrated with the financing of medical and hospital care. According to Morgan, Daw, and Law (2013), "to better manage the pharmaceutical component of their costs, local health authorities in New Zealand centralize formulary management and contract negotiations to a national agency – PHARMAC – that is provided with an annual pharmaceutical budget to work within when negotiating terms of coverage on the national formulary."

Of course, not everyone is a fan of the New Zealand system of drug pricing. Critics state that New Zealand's aggressive approach to drug pricing means patients may not get access to innovative medicines or drugs that would be considered standard elsewhere. This too is up for debate, however, as supporters cite the broad use of generics and low cost of patented medicines in New Zealand as supporting the substantial coverage of the system.

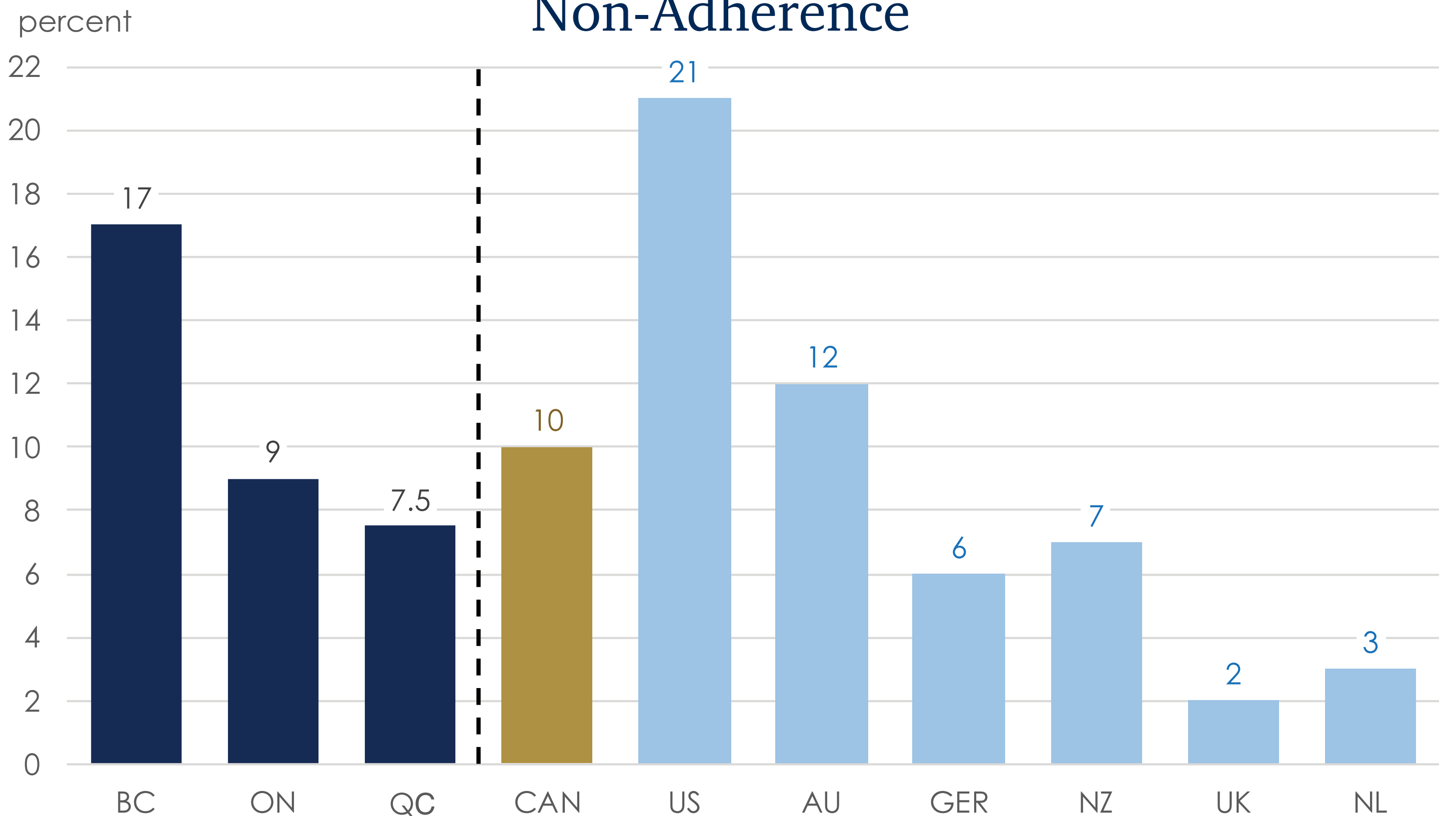
But whether for or against the New Zealand drug pricing system, the question remains: Would it work in Canada? Not surprisingly, the jury remains out on this as well. According to Steven Morgan of the University of British Columbia, "the New Zealand formulary is extraordinarily comprehensive... They reign in on drugs that are specialty drugs that don't have proven value for money and even in that regard New Zealanders still have access to quite a few therapies." Meanwhile, Marc-André Gagnon of Carleton University is on the record as saying, "I don't think it could work here. It's based on the idea

that you have one reference drug per category (referring to the fact that the system only reimburses the lowest-priced drug in each therapeutic category) […] For Canadian doctors, I think they would think this is absolutely unacceptable." Steven Morgan clarifies that the lowest-priced drug reimbursement only occurs with patented medicines, while generic medicine categories have several funded options.

Australia

It is worth contrasting the low rate of cost-related nonadherence in New Zealand with "the high rate of cost-related nonadherence in Australia, which has a universal drug coverage system with a high copayment" (McBride and Bartlett, 2018). Chart 10 illustrates this contrast clearly. Indeed, "among other comparator countries, Australian patients pay the highest copayments – approximately C$35 per prescription. Patients in Germany and New Zealand faced modest copayments – approximately C$7 to $17 in Germany, and C$2 to $8 in New Zealand. Patients face little or no costs for prescription drugs in United Kingdom and the Netherlands" (Morgan, Daw & Law, 2013). It should also be noted that while Australia's copayment is fixed, it does vary by socio-economic status, as measured by income and employment status (Barnieh et al., 2014).

Chart 10: Share of Adults Reporting Cost-Related Non-Adherence



Sources: Morgan, Daw & Law, 2013. Rethinking Pharmacare in Canada. C.D. Howe Institute
Notes: Provincial data came from the 2007 Canadian Community Health Survey and country data came from the Commonwealth Fund 2010 International Health Policy Survey. Due to differences in the data sources, comparisons of the light blue and dark blue bars should be interpreted with caution.

That said, Australia is a federation much like Canada and, as such, may provide some possible points of interest in the Canadian pharmacare discussion. According to Morgan, Daw and Law (2013), "Australia's universal public drug insurance program is administrated at a national level, with public

health insurance programs for medical and hospital care operated at a state level". Drugs are not currently included as an insured health service under the *Canada Health Act*. But, there is a possibility that a model similar to Australia's – where the federal government provides a public drug insurance program – could have some relevance for Canada as we discuss a national pharmacare plan.

United Kingdom

Looking a bit closer to home, as part of the National Health Service (NHS), all UK citizens have their prescription drugs paid for. "In England, most people pay a copayment of $14.50 per prescription, although there are exceptions for vulnerable populations, including children, the elderly and those with certain conditions, such as cancer[…] Wales, Scotland and Northern Ireland have gone further by eliminating copayments on drugs, which increases the chances patients will take required medications" (Healthy Debate, 2015). Indeed, the limited or non-existent copayments in the UK may help to explain why it has one of the lowest shares of adults reporting cost-related non-adherence in among developed economies (Chart 10) (Morgan, Daw & Law, 2013).

And while the UK has managed to control pharmaceutical spending growth to a degree similar to New Zealand, it has done so without a centralized formulary. "Though national prescribing guidance is issued for medicines with particularly contentious clinical or financial implications, systems there have devolved responsibility to regional bodies that must purchase all forms of health care for their local populations. The National Health Service (NHS) in England has even used risk-sharing with individual practices as a means to incentivize physicians to prescribe cost-effectively (Mossialos & Oliver, 2005). The United Kingdom, however, is beginning to re-centralize some management practices, particularly in relation to the negotiation of confidential price rebates for medicines – because devolving such responsibility increases administrative costs and reduces purchasing power" (Morgan, Daw & Law, 2013).

It is also worth noting that "the UK has used lists to define pharmaceutical coverage in a similar fashion to Germany through negative or 'black' lists. The explicit goal of these lists differs from those in Germany, however, as they were meant not only to reduce costs but also to improve the quality of prescribing practices. Unlike Germany, the UK list has not been altered much since its creation in 1984. The UK also operates a 'grey' list, where drugs will only be covered for particular conditions" (Mossialos & Oliver, 2005). A negative list refers to the opposite of a positive list or formulary, which is a list of the drugs that are covered by the insurance plan as opposed to restricted.

Generally, the view on the UK's approach to drug pricing and prescribing seems to be quite positive, as it has both managed to get better pricing and reduce over-prescribing. According to Dr. Marc-André Gagnon, the UK "spends the same percentage of the world market share of prescription drugs as Canada does – despite having twice our population". Dr. Steve Morgan has referred to the NHS as "one of the best systems". Meanwhile, Danielle Martin, VP of Medical Affairs and Health System Solutions at Women's college Hospital in Toronto, has stated that "Evidence-based formularies [like the UK's] can shape prescribing behaviour considerably – it's probably the easiest way to shape behaviour at a mass level" (Healthy Debate, 2015).

Germany

While comparisons can be drawn between the UK and German systems of public drug provision, the latter is very much a bridge between the British Isles and continental Europe. As was mentioned, much like the UK, Germany uses negative or 'black' lists to define pharmaceutical coverage, although it updates its list more often than the UK does. Also like the UK, pharmacists in Germany play an

important role in the health care system through being given extensive prescribing responsibilities in order to help drive down costs. "Since 2002, pharmacists have been allowed to substitute branded prescriptions for non-patented pharmaceuticals unless the physician specifically requests that the prescribed drug is not to be replaced. Policy evaluation has shown, however, that German pharmacists only selectively substitute eligible prescriptions, in part due to the lower profit margins associated with substituted drugs and a lack of incentives to encourage substitution. Moreover, pharmacists might prefer to avoid having to explain to patients that the non-patented drugs are as effective as those written in their prescriptions" (Mossialos & Oliver, 2005).

As described in Mossialos and Oliver (2005), "Germany has maintained an incentive scheme with rewards and sanctions for prescribing behaviour. For instance, collective budgets have been tried and hotly debated. Busse (2000) claims that the initial reduction in drug expenditure following their introduction was mainly attributable to a change in practice by doctors who had previously prescribed drugs of higher quality and greater cost. Junger et al. (2000) showed that the drug budget had no relevant long-term impact on drug prescribing for diabetic patients. Others have documented no consistent pattern of change in prescribing practices attributable to budgeting (Weltermann et al., 1997). Germany has also experienced an increase in referrals to specialists where patients' prescribing costs are met by the hospital budget rather than the GP (Schoffski and Graf von der Schulenburg, 1997). Delnoij and Brenner (2000) maintain, however, that this effect cannot indisputably be attributed only to the prescribing budgets because other changes to the health care system were implemented concurrently."[39]

A major difference between the UK and Germany is the lack of a centralized electronic health record-keeping system in the latter. "For Germany and France, the lack of a centralized information system on prescriber behaviour makes policy evaluation and implementation difficult. The development of computer-assisted prescribing support will offer an improved ability for physicians to monitor themselves" (Mossialos & Oliver, 2005).

France

In contrast to the negative lists used by the UK and Germany, France has a 'positive list' to determine the extent to which some drugs receive reimbursement based on their therapeutic value. And, in the context of copayments (the amounts not reimbursed), France is well known among countries that provide pharmacare (Table 4). It uses both fixed and percentage copayments which do not vary by condition, type of drug, or socio-economic status (Barnieh et al, 2014), while about 100 medicines that are considered to be life-sustaining or that are prohibitively expensive do not require any copayment by users (Gagnon, 2010). And, although "99% of the population has their prescription drugs partially covered by the government[…] the copayments are much larger than the nominal amounts in many other countries" (Healthy Debate, 2015). Government coverage is divided into categories, rating from 0% to 100% coverage, with most drugs getting 65% and the remainder of the cost being covered by copayments. Some vulnerable groups are exempt from copayments, with 93% percent of the remaining population having their copayments covered by private insurance, which is frequently provided by their employers.

TABLE 4: USE OF COST-SHARING & COST-CONTAINMENT POLICIES WITHIN SELECTED OECD COUNTRIES								
	Copayments					MOPL	Cap	Deductible
	Use of Copayment	Vary by Condition	Vary by Drug Type	Vary by Socioeconmic State	Fixed or Percentage			
CAN	VARIES BY PLAN	NO	NO	VARIES BY PLAN	VARIES BY PLAN	VARIES BY PLAN	VARIES BY PLAN	VARIES BY PLAN
AUS	YES	NO	NO	YES	FIXED	FIXED, DEPENDENT ON TYPE OF PATIENT	NO	NO
ENG	YES	YES	NO	YES	FIXED	NO	NO	NO
FRA	YES	NO	NO	NO	BOTH	NO	NO	NO
GER	YES	NO	NO	NO	BOTH	SET AT 2% OF NET INCOME; 1% OF NET INCOME OF CHRONICALLY-ILL PATIENTS	NO	NO
NETH	YES	NO	NO	NO	DIFFERENCE BETWEEN REFERENCE PRICE AND RETAIL	NO	NO	YES
NZ	YES	YES	NI	YES	FIXED	NO	NO	NO

Source: Barniet et al., 2014.

According to Dr. Marc-André Gagnon, the "copayment ladder is intended to help shape the market towards drugs that are more effective or necessary, and away from me-too drugs and non-essential medicines. But because private insurance covers the copayment costs, the effect is basically negated[…] That, combined with a culture of high medicine use in France, has led to higher costs" (Healthy Debate, 2015). Indeed, "the significant role of complementary insurance in France has caused moral hazard since copayments are covered by additional insurance. Top-up insurance has thus limited the impact of French policy aimed at reducing the consumer demand of pharmaceuticals through cost shifting" (Mossialos & Oliver, 2005). Moral hazard in the health care setting refers to an increase in an individual's usage due to the implementation of insurance.

"Despite a successful campaign to encourage the use of generic drugs, France spends more per capita on drugs than many other countries in Europe. France spends about 71% more than the UK, and more than Germany, Denmark, the Netherlands and Sweden. As a result, it also has an unusually high number of pharmacies, and it is number three in overall drug expenditures worldwide" (Healthy Debate, 2015). That said, French citizens have benefitted historically from much lower prices for generic drugs than Canadians have.

Netherlands

Much like France, insured medicines in the Netherlands are listed on a positive list or formulary. However, private insurance companies offer the mandatory core universal insurance package which includes drug coverage as opposed to it being publicly offered.[40] The plan is offered at a set price which does not change for various socioeconomic differences between people. The system is highly regulated by the government so that the private insurance companies cannot refuse people for the

core package, or create addition conditions or cost-sharing mechanisms.

To help control the prices of medicines, "pharmaceutical companies will have to provide proof of the relative efficiency (i.e. cost-effectiveness) of their product when requesting reimbursement for new drugs" (Mossialos & Oliver, 2005). However, drug coverage in the Netherlands is mainly provided at almost no cost to the Dutch, with the exception of the plans that are not the core universal plan, where the patients determine their deductible level.[41] Notably, an interesting takeaway from the Netherlands is their efforts to implement a 1-euro copayment – however the cost of the administration of the copayment cancelled out any revenue made from the copayment.[42]

Another aspect of Dutch pharmaceutical policy is the focus on affecting the behaviour of pharmacists through the use of incentives such as charging fees "equal to a percentage of the difference between the prices of the branded and generic drugs."[43] This incentivizes pharmacists to substitute generic drugs in the place of the prescribed branded drug. This also created a highly competitive market for generic drugs. Another unique aspect to Dutch pharmaceutical policy is the environment in which insurance companies can pair with pharmacists in preferred provider agreements where the pharmacists are given higher volumes of business and the insurance companies have better control over the prices they pay.[44]

Similar to the UK, the Netherlands has made an explicit move "to develop electronic prescribing systems. However, Dutch physicians have little incentive to work with their electronic prescribing system (EPS). Evaluation has concluded that the quality of prescribing may be improved as a result of the EPS but, culturally, Dutch doctors perceive the system as potentially limiting to their professional authority and status" (Mossialos & Oliver, 2005).

LESSONS LEARNED FROM OTHER COUNTRIES

Looking to these countries with offer some form of universal pharmacare, a few guiding principles can be drawn out. Starting with France, United Kingdom, Sweden, Australia, and New Zealand, Gagnon (2010) concluded that when compared to Canada: 1) the citizens of these countries spend a great deal less on drugs while consuming an equal or greater amount, 2) citizens in the countries pay much less for their medications, 3) except for Australia, all of these countries have had more success in suppressing inflation in drug prices, 4) these countries made less use of private funding, and 5) these countries were in a much better position to attract pharmaceutical investment than Canada (despite paying higher drug prices than most other countries, pharmaceutical R&D expenditures in Canada are very low relative to other countries that spend much less on drugs).

Other lessons learned include:

1. Copayments and deductibles introduce financial barriers that may increase nonadherence, particularly among financially constrained individuals and households. As such, most jurisdictions that charge copayments and deductibles take ability to pay into account. That said, given the Dutch example, copayments must be sufficiently high so as to cover the administrative cost of maintaining them, and the more layered the copayment structure the higher the administrative cost.
2. Positive lists or formularies seem to be used more commonly than negative lists, and allow for greater control over drugs available for prescription.
3. Centralized formularies and price negotiations lead to lower costs than a decentralized approach to negotiating by regional or local authorities.

4. Financial incentives to induce behaviour by doctors and pharmacists to cut costs by substituting generics for brand-named drugs can support better cost and adherence outcomes as well as reducing overprescribing.
5. Well-functioning electronic health record-keeping can support a greater integration of health services and the potential to reduce overprescribing.

POTENTIAL COST OF A NATIONAL PHARMACARE PROGRAM IN CANADA

Having now discussed the context for a national pharmacare program in Canada, the next step is to examine what it will cost. The generally-accepted approach to costing in possible national pharmacare programs in Canada is to use pharmacy level data provided by IQVIA (formerly IMS) and information on public drug spending from the Canadian Institute for Health Information (CIHI). Using this information, several research papers have been published which provide a range of estimates from a national pharmacare program with universal coverage for essential medicines to a more expansive, comprehensive formulary.

Cost of an Essential Medicines National Pharmacare Program

A 2017 research paper by Dr. Steven Morgan and three co-authors estimated effects of universal public coverage of essential medicines. This incremental approach to a pharmacare program in Canada is interesting since this study demonstrates that it "could address most of Canadians' pharmaceutical needs and save billions of dollars annually."[45]

Using the CLEAN Meds list as the formulary for essential medicines, plus chemically similar drugs, the authors estimate the costs associated with universal federal coverage. They estimated that Canadian expenditures on prescription drugs would decrease by $3.04 billion which would involve an increase in government costs by $1.23 billion per year with private sector savings of $4.27 billion per year.

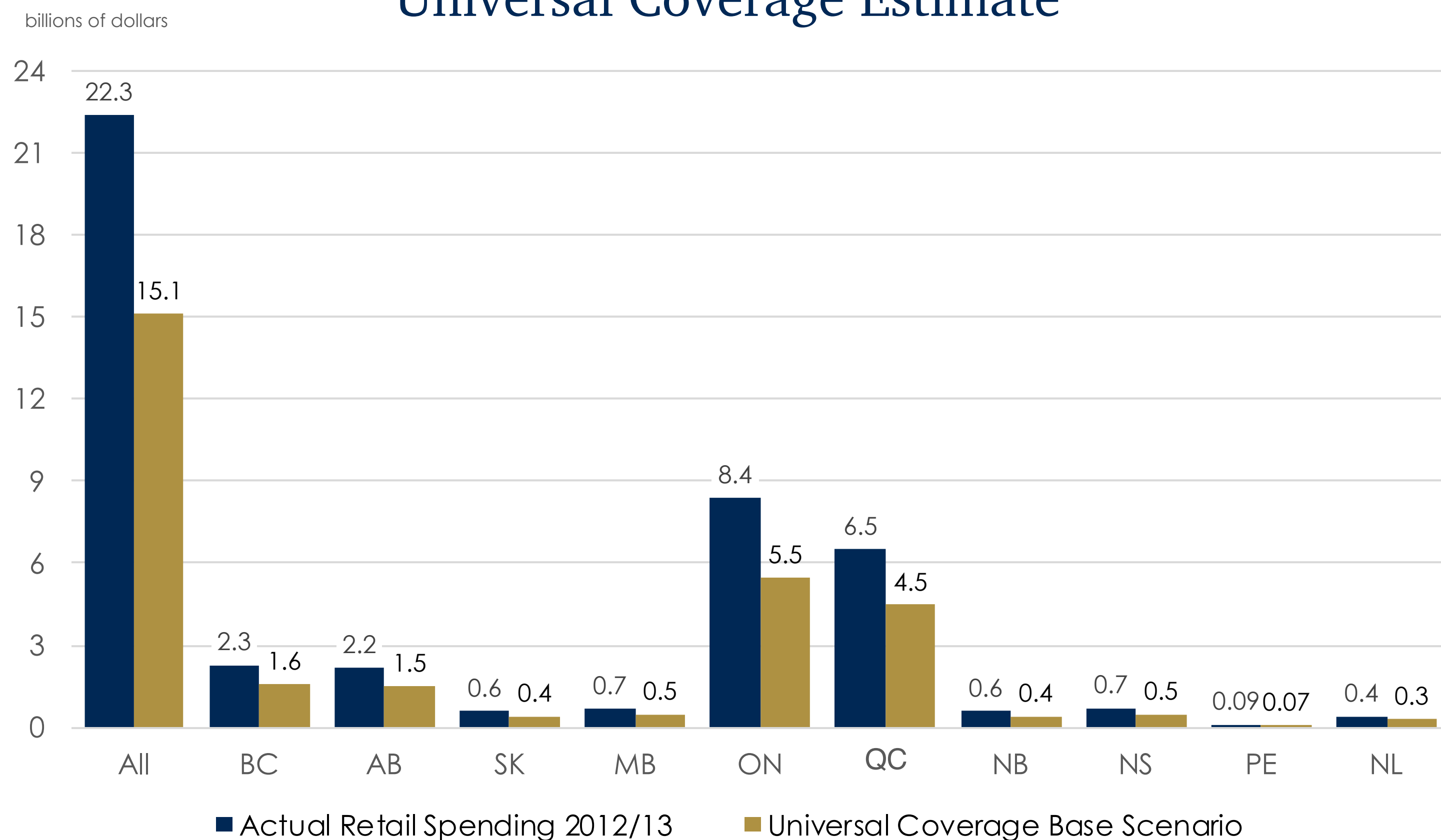
It's important to note that the authors believe that universal public coverage for essential medicines is a step forward towards "more comprehensive pharmacare reforms."[46] As such, this incremental approach could underpin a national comprehensive drug plan at some future point.

Cost of a Universal and Comprehensive National Pharmacare Program

Nearly a decade ago, Gagnon (2010) published a research report which quantified the net reductions in costs which would result from the introduction of universal pharmacare under varying industrial policy assumptions. The first scenario examined universal pharmacare with the same industrial policies linked to drug costs that existed at the time. Dr. Gagnon observed that the net reduction in the cost of pharmaceuticals would be $2.95 billion in the reference years, or savings of 11.7% relative to total baseline costs of around $25 billion. In the second scenario, Dr. Gagnon examined universal pharmacare with industrial policies linked to drug costs which have been revised to be in line with those of other OECD countries. He estimated net cost reductions of $4.47 billion (17.8% of total costs). Universal pharmacare with stronger industrial policies (indexing drug prices to the three highest comparator countries) was the third scenario presented by Dr. Gagnon, which resulted in net cost reductions of $2.67 billion (or 10.6% of total costs). In the final scenario Dr. Gagnon presented, he estimated that universal pharmacare with cancellation of the industrial policies artificially inflating drug prices (thereby taking the same approach as New Zealand) would reduce net costs by $10.7 billion (or 42.8% of total costs). In all, regardless of the industrial policy pursued under each of these scenarios, the introduction of universal pharmacare led to a marked reduction in net costs of pharmaceuticals in Canada.

Another past research paper, published by Dr. Steven Morgan and four co-authors in 2015, also estimated the cost of a universal and comprehensive pharmacare program in Canada. The authors estimated that there would be a reduction in spending on prescription drugs by an average of $7.3 billion annually, increasing the costs to government by an average of $1.0 billion. Chart 11 demonstrates the estimated savings for citizens in every province with the introduction of a universal and comprehensive national pharmacare program.

Chart 11: Actual Drug Retail Spending vs Universal Coverage Estimate

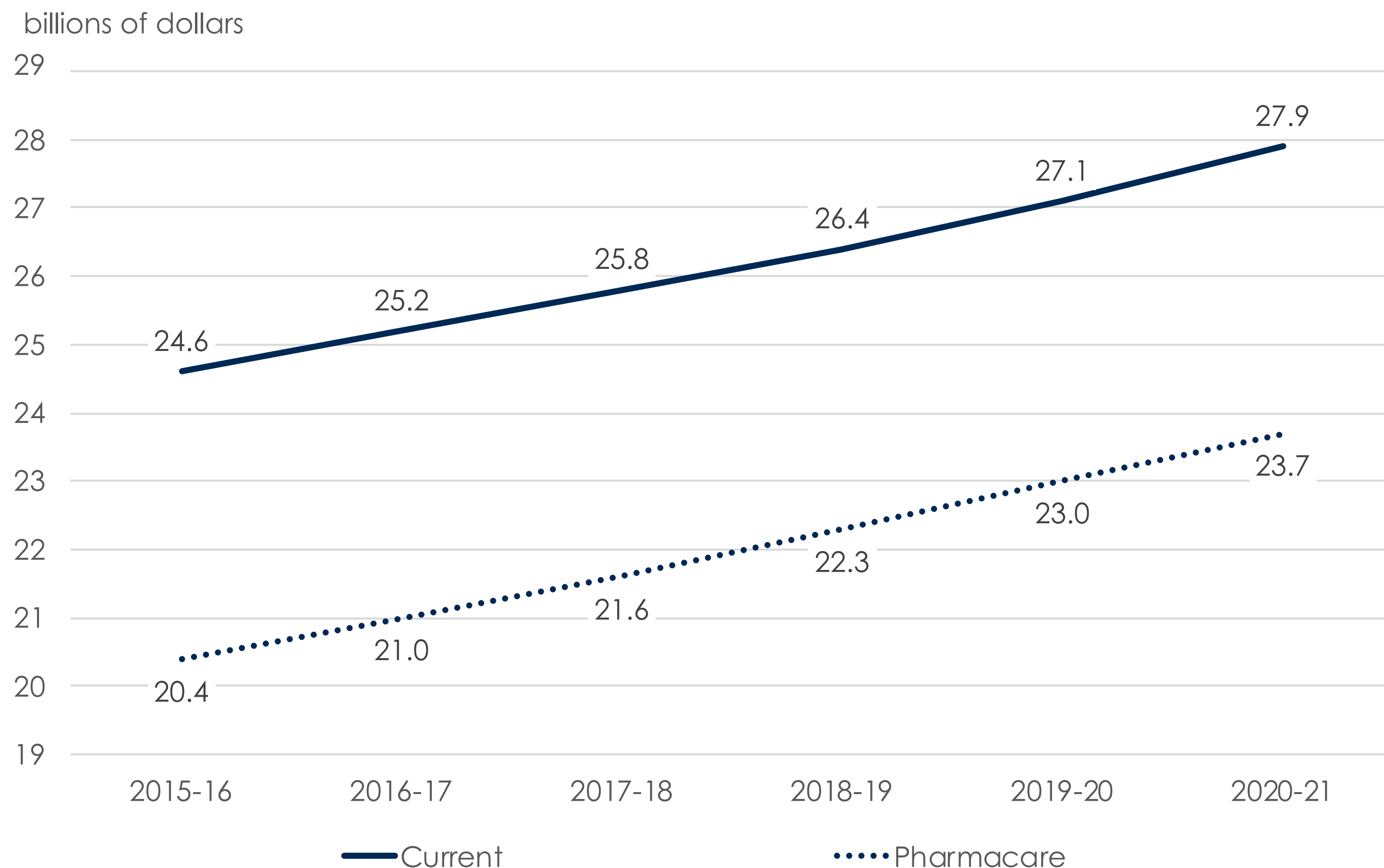


Sources: Steven Morgan et al., 2015. Estimated cost of universal public coverage of prescription drugs in Canada
Note: In all provinces, a universal drug coverage program would reduce drug expenditures. The authors also calculated worst-case and best case scenarios. The chart only demonstrates the base scenario.

In September of 2017, the Parliamentary Budget Officer (PBO) released its own federal cost estimate of a national pharmacare program. It presented a cost estimate using the comprehensive Quebec formulary, which calculates a figure that is determined to be welfare maximizing for society as a whole. The PBO (2017a) estimated that $28.5 billion was spent on drugs in 2015, with $13.1 billion paid for by public insurance, $10.7 billion by private insurance, and $4.7 by individuals.[47] The PBO provide the statistic that 2% of Canadians lack any sort of drug insurance while 10% have coverage but lack the financial means of paying for their prescriptions. Of the $28.5 billion in total drug expenditure in Canada in the 2015-16 fiscal year, Canadian pharmacare programs at the time would have covered approximately $24.6 billion of this total with the remainder having gone towards drugs not covered on the Quebec formulary. The PBO estimated that a nationwide pharmacare program would cost the Government of Canada $20.4 billion if implemented in fiscal 2015-16, representing $4.2 billion in savings overall (Chart 12). By the 2020-21 fiscal year, the annual cost of a national

pharmacare program was projected to reach $23.7 billion, with annual savings projected to remain at around $4.2 billion. The PBO provides four factors responsible for this cost-saving outcome: a stronger negotiating position for the government, the universal application of generic drug substitution, public coverage of a select number of drugs, and a small revenue from copayments for brand-name drugs.

Chart 12: Total Spending on Drugs Eligible for Pharmacare



Source: Parliamentary Budget Officer, Federal Cost of a National Pharmacare Program, 2017.

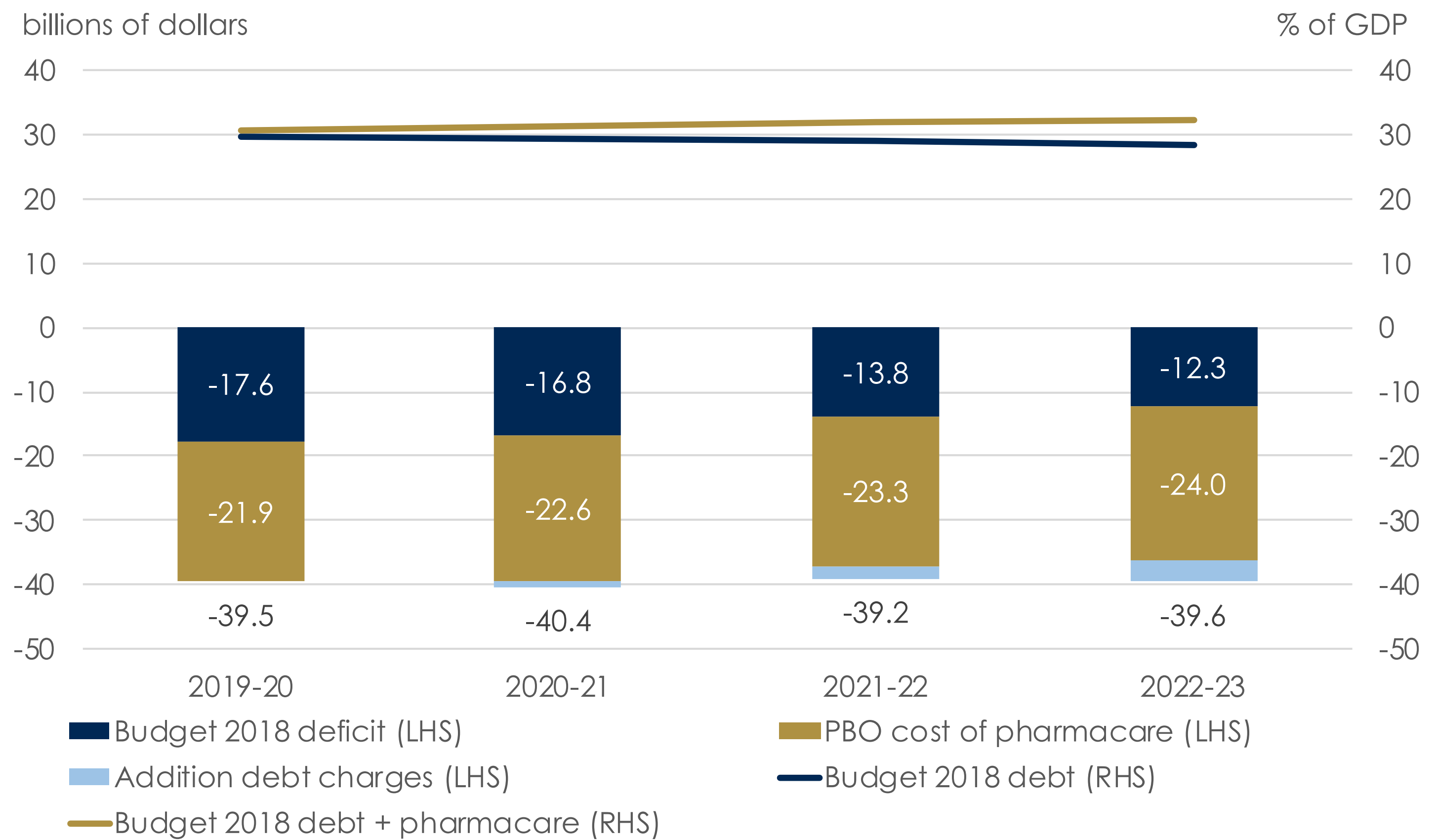
The Fiscal Impact of a National Pharmacare Program in Canada

The one consistent conclusion in all of these studies is that the introduction of a universal pharmacare program in Canada will reduce net costs countrywide. But it is important to note that it will also result in a migration of costs from consumers and employers (who provide private insurance to their employees) to governments.

In the most extreme case presented above of universal pharmacare using the Quebec formulary – the most comprehensive provincial formulary – the cost of pharmacare in Canada would fall from a projected $27.1 billion to $21.9 billion in the 2019-20 fiscal year, for savings of $5.2 billion that year. But while the aggregate cost will fall, the federal government could bear this full $21.9 billion cost burden. Using the Government of Canada's fiscal outlook from Budget 2018 and supplementing it with the projected cost of a national pharmacare plan from the PBO (2017a), it can be observed that the budget deficit would almost double over the medium term (Chart 13). Meanwhile, the debt-to-GDP

ratio would shift higher and would rise over time, implying that federal finances are likely to be rendered fiscally unsustainable if this trend were to continue. Should the federal government implement the pharmacare program outlined in the PBO report and wish to maintain the debt-to-GDP ratio, it would necessitate a 2-point increase in the GST.

Chart 13: Federal Fiscal Impact of National Pharmacare



Sources: Government of Canada, Parliamentary Budget Officer, Institute of Fiscal Studies and Democracy.
Note: Pharmacare cost values for the 2021-22 and 2022-23 fiscal years are determined by applying the growth rate in the PBO pharmacare cost estimate for the 2020-21 fiscal year to those fiscal years.

As a result, it can be inferred that any scenario which shifts the cost of national pharmacare to the federal government would need to be less generous than the comprehensive coverage offered under the Quebec formulary. Indeed, the IFSD estimates put the fiscal room available to the federal government, while still maintaining at 31.0% debt-to-GDP ratio, at about $5.8 billion in the 2019-20 fiscal year, rising to $16.0 billion by the 2022-23 fiscal year. But, while this range of fiscal room estimates likely rules out the most comprehensive formularies, it provides ample room from the introduction of a national pharmacare program based on a less comprehensive list of drugs, such as an essential-medicines list. Of course, this analysis also assumes that the federal government does not choose to improve its fiscal position by raising additional revenues or cutting spending elsewhere – options it has shown very little interest toward in the past.

But regardless of the actions taken by the federal government toward a national pharmacare program, with the provinces being broadly in a fiscally unsustainable position currently, cost sharing of national

pharmacare would leave them even that much worse off. Indeed, analysis by the Parliamentary Budget Officer (2017b) has illustrated this national fiscal imbalance clearly - a conclusion repeatedly reached over the near decade the PBO has produced its Fiscal Sustainability Reports (Chart 14).[48] Expanding pharmacare benefits without increasing revenues or cutting spending elsewhere at the subnational level of government to offset the additional cost of pharmacare will only exacerbate this problem.

Chart 14: Government Net Debt relative to GDP

percent of GDP

125
100
75
50
25
0
-25
-50
-75

2011 2021 2031 2041 2051 2061 2071 2081 2091

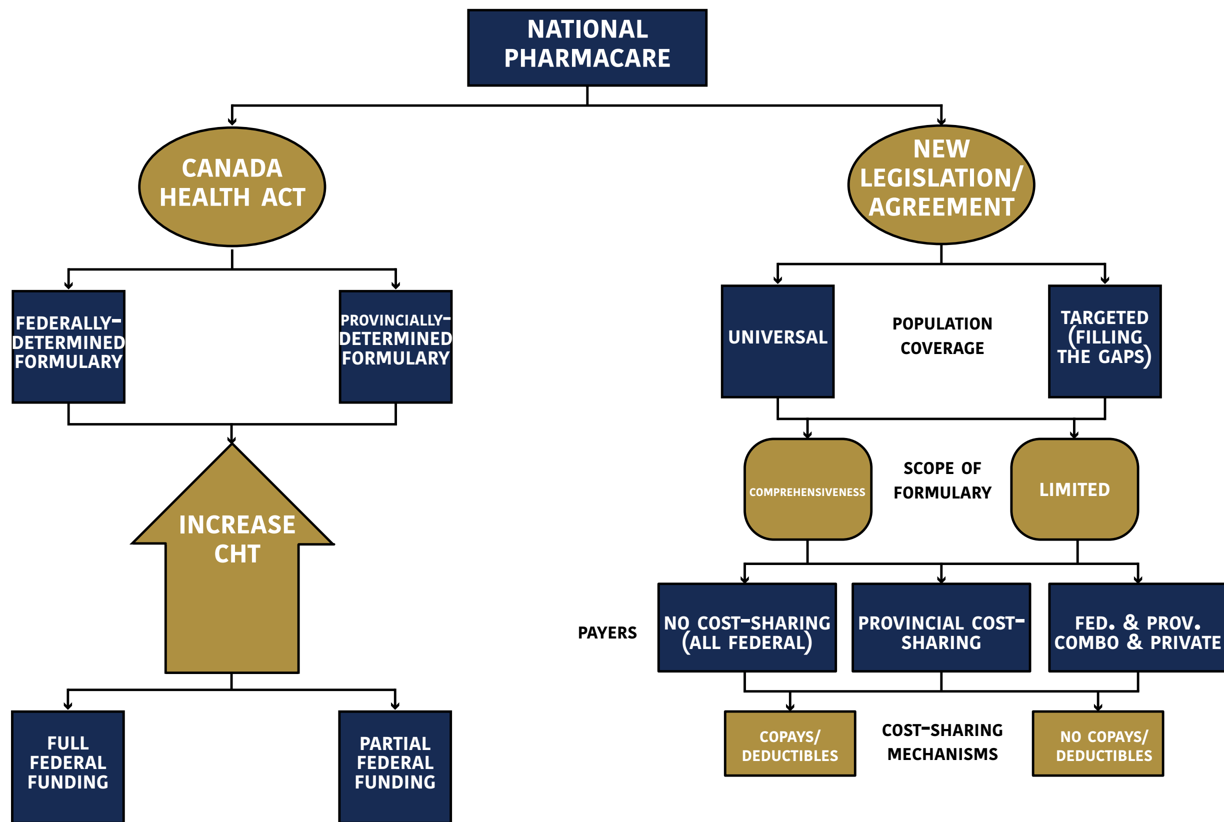
Federal government — Subnational governments — Public pension plans — Total government

Sources: Statistics Canada, Parliamentary Budget Officer.
Notes: The projection period covers 2017 to 2091, and can be found in the PBO's Fiscal Sustainability Report 2017.

NARROWING OF OPTIONS

Taking all of the information presented so far in this report into account, this section lays out the key considerations that ringfence the national pharmacare debate. It will follow the structure of flowchart in Chart 15.

Chart 15: National Pharmacare Decisions



PHARMACEUTICAL COVERAGE AND THE *CANADA HEALTH ACT*

Pharmacare is not currently considered in the *Canada Health Act*. Indeed, only drugs that are provided as part of hospital services are included. But the federal government could add pharmacare to the *Act* by including a drug formulary to the list of insured health services. In doing so, this addition would require a pharmacare program to adhere to the five aforementioned principles – public administration, comprehensiveness, universality, portability, and accessibility. Notably, adding a drug formulary to the list of insured health services is in line with Recommendation 2 of the HESA report: "That the Government of Canada amend the *Canada Health Act* to include drugs prescribed by a licensed health care practitioner and dispensed outside of hospitals in accordance with a common voluntary national formulary, as part of the definition of an "insured health service" under the *Act*."[49]

In the context of the principle of public administration, the inclusion of a drug formulary as an insured service would need to be administered and operated by a non-profit public authority. Given this principle, drug coverage stemming from within the *Canada Health Act* would likely adhere to the same insurance structure of the current insured health services, which follows a single-payer model, as is recommended in the HESA report.

Should prescription drug coverage fall under the *Canada Health Act* as an insured health service, the provinces and territories would need to provide this coverage in order to be eligible for the entire CHT,

as dictated by the principle of comprehensiveness. However, the decision of which drugs to cover could lie with either the federal government or the provinces and territories. This would depend on whether the *Act* includes a specific formulary or simply the "provision of drug coverage" as the insured health service. If the *Act* is amended to include a specific formulary created by the federal government, then provinces and territories would have to provide coverage for that formulary in order to receive the entire CHT. If the *Act* only dictates that provincial-territorial insurance plans cover prescription drugs, then the decision of which drugs are medically necessary and, therefore covered, will lie with the provinces and territories individually. An option that falls between these two choices could include a federal essential medicines list where provinces and territories can decide to include other drugs deemed to be medically necessary, as outlined by the *Act*.

Under the *Canada Health Act*, the principle of accessibility would ensure that all insured persons have access to the formulary of drugs without discrimination and without a deductible or similar charge, such as a copayment. Indeed, section 18 of the *Act* prohibits extra-billing and user charges by medical practitioners for insured health services. Currently, hospital and physician services, both of which fall under the *Act*, are first-dollar covered, which means there is no deductible whatsoever for insured persons accessing the insured health services.[50] This may limit the ability to implement cost-sharing mechanisms, such as copayments and deductibles, under a national pharmacare plan. A possible mitigation to the inability to implement cost-sharing mechanisms is to create (or keep) the various provincial programs which exclude low-income people from bearing the burden of any cost-sharing mechanisms. For example, the Ontario Drug Benefit for low-income seniors removes the deductible and lowers the copayment that seniors below the low-income threshold must pay.

In the context of a national pharmacare program, the principle of portability can be applied in a similar manner to how it is being applied now in regard to billing agreements. Any medically necessary drugs received out-of-province/territory could follow the same billing agreements that currently cover the insured health services. An out-of-province/territory person would pick up their prescribed drugs and the host province or territory would bill the home province or territory for the cost of the drug.

Another option, should the billing agreements not cover drugs, would be the requirement for patients to seek reimbursement from their home province or territory for the cost of the drug. However, the sale price of these drugs at provincial or territorial levels may differ, which puts a cost burden on the patient.

Notably, some important questions arise regarding the functionality of this principle:

1. Could different provinces and territories bill differently for the same drug?
2. Will there be more than one buyer for the entirety of Canada, e.g. provinces buy drugs for hospitals and pharmacies buy the remaining drugs?

Due to the principle of universality, a program cannot only cover certain groups of insured persons and not others. In this context, it is important to note because Budget 2018 and subsequent comments by federal officials suggest that the Government of Canada intends to use a national pharmacare program to fill existing gaps in provincial-territorial plans as opposed to providing a universal system of coverage. This would not be possible under the *Canada Health Act*.

It should be noted that the provision of drug coverage need not be considered an insured health service under the *Act*, however, the volume of amendments that would be needed increases

substantially should new sections and definitions specific to drug coverage enter the legislation. For example, four of the five principles (excluding the principle of public administration) would need to be amended to alter the language to include the provision of drug coverage alongside the provision of insured health services.

In further support for the unlikelihood of the use of the CHA for pharmacare, Finance Minister Bill Morneau has said that a national pharmacare program must be "fiscally prudent," although this is never defined. Under the *Canada Health Act*, the program would also have to be portable within Canada and also provide universal access to all Canadians, which calls into question the use of deductibles and copayments, which are known to reduce adherence to prescriptions, particularly among low-income households.[51] So, without some cost-sharing mechanisms, the federal government may instead opt to restrict the scope of a national pharmacare program introduced under the *Act*.

Pharmaceutical Coverage and the Canada Health Transfer

The CHT is legislated within the *Canada Health Act* as a cash contribution from Parliament to the provinces and territories. The transfer is conditional upon the provincial and territorial health insurance plans adhering to the conditions and principles of the *Act*. In the current form of the *Act*, insured health services include physician, hospital, and surgical-dental services which much be covered within the various provincial-territorial insurance plans. If the *Act* is amended to include the provision of prescription drugs as an insured health service, then the CHT would be conditional upon the provinces and territories including this service in their insurance plans. However, this does not necessitate an increase in the CHT, which could put the burden of financing a national pharmacare plan on the provinces and territories. Of course, the federal government could also increase the CHT to help cover the costs of including drug coverage in insurance plans. But this re-negotiation seems implausible given the acrimonious nature of the recent negotiations that led to bilateral agreements being signed by the federal and provincial-territorial governments in early/mid-2017.

Another possible route to a national pharmacare program would be the creation of an entirely new transfer. This new transfer would be conditional on either the *Canada Health Act*, with the necessary amendments, or more likely, a new agreement altogether. However, with the creation of a new transfer under a new agreement, the guiding principles of the *Act* will not apply. This may leave room for more flexibility for provinces, territories, and the federal government to structure a pharmacare program that does not necessarily have to align with the five principles of the *Act* or require a renegotiation of the *Act* with the provinces and territories. For example, the prohibition of user charges and extra-billing would restrict the use of cost-sharing mechanisms such as copayments and deductibles under the *Act*, but this restriction may not apply under another agreement unless it is explicitly included.

If the *Canada Health Act* is ruled out as a foundation for a national pharmacare program, the way forward for the federal government is to:

1. Create new legislation for the national provision of drug coverage;
2. Create new legislation with a transfer to provinces and territories conditional on the provincial provision of drug coverage; and/or
3. Come to agreements with the provinces and territories in a way similar to the home care and mental health funding agreements struck in 2017.

Currently, the CHT is doled out on a per-capita basis and nearly every Canadian is covered under the *Canada Health Act*. However, if a pharmaceutical transfer is paid to provinces and territories outside

of the *Act*, the federally-covered populations will have to be taken into account and could potentially reduce the transfer amounts to jurisdictions with higher proportions of covered populations, such as the Territories, Manitoba, and Saskatchewan.

Creation of a New Act and Transfer for National Pharmacare

The *Canada Health Act* and the CHT are important for the contextualization of Canadian health policy. But the *Act* is restrictive and would require several changes before it could include prescription drug coverage.

The *Canada Health Act* is not the only route, or even necessarily the best route, to a national pharmacare program in Canada. Certain aspects of the current Canadian health system fit nicely with a national pharmacare program. In general, the provinces and territories administer the system with cost-sharing from the federal level.[52] This doesn't require pharmacare to fall under the *Act* or be funded through the CHT.

A new act specifically created for a pharmacare program could be tailored to the specific Canadian context, granting administrative authority to provinces and territories and outlining the federal responsibility for cash contributions in the form of a pharmacare transfer. If a pharmacare program no longer has to follow the principles set by the *Canada Health Act*, that means public administration, universality, comprehensiveness, accessibility, and portability no longer have to be guiding principles. However, much of the research demonstrates that a program fitting most of these principles is more suitable for the desired outcomes. For instance, a universal, single-payer, comprehensive, and accessible pharmacare program is one recommended by several experts.[53]

If new legislation is passed for a national pharmacare plan, it could take on a similar structure to the *Canada Health Act* and create its own transfer as well. The language within such legislation could be more detailed and specific for any form of drug coverage. The creation of new legislation would fall under the same constitutional authorities that the *Act* falls under, giving the federal government spending authority even in provincial jurisdictions. However, it is unclear whether the provision of prescription medicines is under either authority since drugs were not considered in 1867.

Pharmacare Transfer without Accompanying Act

The recent health agreement between all provinces, territories, and the federal government outlined two priority areas, home care and mental health.[54] Although the agreement is beyond the scope of the *Canada Health Act* and is therefore not delivered through the CHT, it demonstrates the structure of a potential national pharmacare program that falls outside the *Act* . Outlined in the federal Budget 2017, $11 billion over 10 years is invested in the federal government's two priority areas.[55] The federal funding is in addition to that of the CHT, and the funding agreements explain the various components of the bilateral agreement. The details of these agreements are still being released but Saskatchewan's agreement, for example, outlines the objectives, financial allocations, performance measurement, and many other details.[56] The federal government reserves the ability to terminate the agreement, and therefore funding, should the province or territory fail to meet the agreed upon conditions.
The conditions include providing data to CIHI and an annual financial statement that references the "action plan" of the province or territory. This agreement not only demonstrated the commitment to work towards a health care system that meets the changing needs of Canadians, but also outlined the accountability measures that will focus on common indicators in the priority areas.[57]

It is important to stress the value of measurement mechanisms. In Budget 2018, the federal

government proposed new legislation that incentivizes provinces and territories to correct any deviations from the conditions set by the *Canada Health Act* in order to receive the entire CHT. There must be mechanisms put in place to incentivize provinces and territories to deliver the services and guarantee that funding through a transfer is going towards those services.

Similar to the home care and mental health agreement, it's possible for the federal government to offer funding to provinces and territories to provide drug coverage that follows certain criteria or conditions. Based on the analysis contained in this report, a universal pharmacare system is a likely way to achieve the desired outcomes that politicians as well as researchers have outlined over the years. An important decision to make is which government(s) will have the authority over determining the formulary for a pharmacare program. Once that decision is made, the formulary does not need to be stagnant and there can be plans to add to the formulary as the program develops. As well, any specific considerations around the structure of the program can also be included in the partnership agreement.

A potential downside to such an agreement would be the uncertainty of future governments upholding the agreement. For provinces and territories to enter such an agreement would also put them at risk of someday losing the funding from the federal government.

With the development of pharmacare agreements with each province and territory comes many decisions to be made. The first step must be to determine what a pharmacare program is trying to accomplish. The answer to that question will shape the various components of the program – coverage type, who the payers are, and which drugs are on the formulary/formularies.

Universal versus Targeted Pharmacare Coverage

Under the *Canada Health Act*, the provision of drugs as an insured health service would require pharmacare to be universal. The program would have to cover all insured people under a provincial or territorial health insurance plan. There is a plethora of research to support the administrative and fiscal efficiencies and, of course, equity of a universal program over any other form.[58, 59, 60, 61] As such, while universality may be a binding principle under the *Act*, it would be a positive characteristic for any national pharmacare program, including one which does not fall under the *Act*.

If pharmacare does not fall under the *Canada Health Act*, the program has much more flexibility depending on the legislation or agreement that is created. For instance, a targeted approach is another option for the coverage structure. A population-targeted pharmacare program would cover only those individuals that the program aims to cover, such as certain groups or populations that are not currently covered by private or public plans already in place. Most provinces and territories already have a targeted structure for their public drug coverage, differing by which populations are targeted and by cost-sharing mechanisms. However, picking apart the various public and private plans to determine which people require coverage is quite tedious and administratively difficult. The groups that are currently underinsured are generally self-employed, part-time employed, or precariously employed (Health and Finance Ministers, 2018). Determining which Canadians fall into these categories would come with many challenges. This could involve expanding public coverage or incentivizing firms to expand their private coverage. However, as mentioned in a discussion paper published by the Government of Canada, "this gap filling approach could perpetuate existing inequities and inefficiencies of our existing patchwork system unless standards are developed".[62]

A non-universal pharmacare program does not necessarily focus on specific demographics but could also focus on protecting individuals from exceptionally high drug costs, called catastrophic coverage.[63]

This type of coverage typically involves out-of-pocket maximums, or caps, which prevent an individual from paying large amounts of their income towards prescription drug expenses. However, the difficulty lies with determining the correct threshold for coverage.[64] As well, this form of coverage does not promote equity or aid in the control of drug costs which is a root cause of the inaccessibility to prescription drugs for Canadians.

Single-Payer versus Multi-Payer National Pharmacare Program

The *Canada Health Act* prescribes the principle of public administration for all provincial and territorial health insurance plans. But this only requires that the plans be administered by a public, non-profit authority and does not necessarily require a single-payer system.

That said, the evidence in favour of a single-payer system is strong, as detailed in the HESA report. PBO (2017a) assumes a single-payer system and describes the various benefits including greater purchasing power and administrative efficiencies.

This component of a national pharmacare program is not easily determined since there are more options than just single- vs. multi-payer. For example, the federal government could bear the entire cost of the pharmacare program, whether paying provinces and territories to administer or not. Alternatively, the federal government can reach agreements with provinces which include transfers of funding in return for the provision and administration of drug coverage under certain conditions.

As well, the federal government, provincial-territorial governments, and private insurers can be payers for a pharmacare system with private insurance having the ability to "top-up" the public plans. The concept of private insurance "topping-up" the public coverage is one that is constantly debated in policy circles. For instance, Dr. Marc-André Gagnon argues that having multiple payers diminished purchasing power.[65] However, if private insurance companies do not have the opportunity to supplement any universal public coverage, people may lose coverage they currently enjoy from private insurance companies.

Comprehensive versus Essential Medicines Only

Under the *Canada Health Act,* a formulary that may accompany a national pharmacare program could be a comprehensive and relatively large list of drugs. A comprehensive public pharmacare program would be an equitable and efficient strategy to achieve access to necessary and affordable care for all Canadians. Alternatively, an incremental approach to a more comprehensive formulary could be an essential medicines formulary that the current public or private plans could top-up. And, as Steven Morgan and his co-authors write, "adding universal public coverage of a model list of essential medicines to the existing complement of public drug plans in Canada could address most of Canadians' pharmaceutical needs and save billions of dollars annually."[66] If Canadians want pharmacare to promote the accessibility of medicines for everyone, a universal essential medicines program would increase access to drugs undoubtedly.

Assuming that the authority over the formulary falls to the federal government, whether under the *Canada Health Act* or not, then the provinces and territories would need to provide coverage for a federally-specified formulary if they wish to qualify for the CHT or an equivalent transfer. This formulary would be national in scope and provide the same coverage to all Canadians. An essential-medicine formulary would ensure that all Canadians have access to basic essential medicines, but this approach would not cover the entirety of the drugs that can be prescribed in Canada, including those which are exceptionally high cost.[67] It would therefore only provide the basis for a national

pharmacare, with the remainder of the comprehensive provincial-territorial formularies being provided by subnational jurisdictions. Therefore, an essential-medicine formulary to complement the current patchwork system of public and private coverage may be a practical step towards a more comprehensive program.

But the discussion should not end there. Taking a more comprehensive approach to a national formulary would provide coverage for high cost drugs as well as a much broader range of medicines. This would ultimately provide coverage to more Canadians as well as a larger base for more purchasing power due to the extensive market share and negotiating power.[68]

Cost-Sharing Mechanisms

If pharmacare is provided under the *Canada Health Act* as an insured health service, keeping sections 18 and 19 as they currently read, then copayments, deductibles, and premiums would be forbidden as they qualify as either user charges or extra-billing. Amendments to these sections could make room for various cost-sharing mechanisms. However, these mechanisms should not create a program in which the inability to pay is a coverage factor. As was previously discussed, many OECD countries have various cost-sharing mechanisms for residents who can afford to pay a copayment. However, the use of even small copayments has been shown to increase cost-related non-adherence to drug therapy.[69] And a copayment that is too low can be more administratively burdensome than it is worth.

That said, some cost-sharing mechanisms such as copayments and deductibles can be used to incentivize the use of generic medications when available which can help control expenditures. As such, unless the prescribing physician provides a reason for non-substitutability, a brand-name medicine with a generic substitute could come with a copayment.

Another form of cost-sharing is out-of-pocket limits which put a maximum on how much a patient can pay out of their own pocket before receiving more generous coverage, usually full coverage. This helps mitigate the burden of exceptionally high-cost medication, and also the financial burden of requiring multiple medications.

Pharmaceutical Research, Innovative Development, and Investment

A common concern when a universal, single-payer, comprehensive pharmacare program is proposed is that innovative and new drugs will not be released into the Canadian market. For instance, New Zealand is often held up as the example of a country with national pharmacare that restricts access to innovative, and at times even standard, medicines. However, Dr. Steven Morgan argues that “the New Zealand formulary is extraordinarily comprehensive,” that “they reign in on drugs that are specialty drugs that don’t have proven value for money and even in that regard New Zealanders still have access to quite a few therapies.” He also argues that, even though there may be only one reference drug per therapeutic category, there are plenty of drugs covered in those “therapeutic categories with lots of generics” (Health Debate, 2015). As such, it seems that the argument linking national pharmacare to reduced access to new and innovative medicines is more specific to the formulary being used and how pricing is determined as opposed to national pharmacare itself. Indeed, as national pharmacare would increase access to drugs among some groups that are currently uninsured in Canada, sales volumes of patented and unpatented medicines in Canada could actually increase.

Concerns are often also expressed in the context of a national pharmacare plan around the implications it could have for aggressively bringing down drug prices and, therefore, reducing access to innovative drugs and investment in research & development. But it should be noted that while drug

pricing and a national pharmacare program are related, they are not one and the same. Instead, drug pricing in Canada is the purview of the Patented Medicines Prices Review Board (PMPRB) and the pan-Canadian Pharmaceutical Alliance (pCPA) (Annex 3 has more information regarding these two organizations).

Further, Gagnon (2010) shows that comparable countries to Canada with lower prices of patented drugs can have higher levels of drug research and development (R&D).[70] For example, France's patented drug prices were 85% of Canadian prices in 2006-07. However, drug research and development (R&D) made up 22% of French domestic sales, as compared to only 8.1% of Canadian domestic sales. This example demonstrates that although Canadians pay higher prices for patented medicines, they are not rewarded with higher levels of R&D.

Implications of the Discussion Paper from the Federal Ministers of Health and Finance

The discussion paper from the federal Ministers of Health and Finance asks many important questions. One of them is who should be covered, with the federal government going on to ask respondents whether coverage should be universal, income-tested, or some other criteria. Universal coverage could be legislated through changes to the *Canada Health Act*, as was discussed earlier, although this conflicts with comments made by Finance Minister Bill Morneau following Budget 2018. Indeed, at no point in the discussion paper do the Ministers of Health and Finance ask respondents if they believe the *Canada Health Act* should be changed to include pharmacare as an insured health service. But doing so would enshrine universal drug coverage in law.

Instead, Minister Morneau expressed his preference for a national pharmacare program that will close existing gaps. A form of this gap-closing approach could be one that is income tested, thereby supporting low-income people in getting access to needed medicine. But, importantly, drug benefit programs that are income-tested already exist in most provinces and territories in Canada, rendering it somewhat moot. According to the Ministers of Health and Finance in their discussion paper, gaps in current drug coverage instead tend to be found among Canadians that are self-employed (so lack employer-provided health insurance), employed on a part-time basis, or are precariously employed (e.g. taking temporary contracts). These Canadians may not be heavy users of pharmaceutical drugs generally but may fall through the cracks when they are needed.

Looking to the question of 'How should national pharmacare be delivered?', the choices offered by the Ministers of Health and Finance are: 1) through public insurance (like coverage for hospital and physician services), 2) through a mix of public and private insurance (such as existing drug coverage or other services like dental care), or 3) some alternative. This question can be addressed by the report from the Standing Committee on Health, which received multi-partisan consensus on the need for a universal, single-payer national pharmacare program as opposed to a mixed public-private system similar to the system that currently exits.

Addressing which drugs should be covered, the discussion paper suggests three categories: essential medicines, most frequently prescribed drugs, and a more comprehensive approach. Of course, these drug categories are not mutually exclusive, with many essential medicines being a subset of frequently prescribed medicines and most certainly a subset of a more comprehensive list.

When expanding on the question 'Which drugs should be covered as part of a national pharmacare plan?', the federal government points to only safe, effective prescription drugs for which there is good evidence of value for money or those drugs plus others for which there is less evidence of value for

money. Again, with Finance Minister Bill Morneau's comments on fiscal responsibility concerning pharmacare, it is tough to see the federal government funding a more comprehensive approach to drug coverage in Canada. Instead, a more limited formulary, such as one comprised of essential medicines or most frequently prescribed drugs, seems more within the federal government's thinking.

Another question raised in this same section of the discussion paper is 'How much variability across different drug plans or jurisdictions should there be in the list of drugs covered by national pharmacare?' The responses broadly narrowed to two choices: a common national list with no variation or a common approach with some allowance for variability depending on unique circumstances. Reading between the lines of past federal government statements suggests that Finance Minister Morneau prefers a targeted approach to a national pharmacare plan, pointing to a preference for variability across different drug plans.

Finally, the Ministerial discussion paper asks the all-important question: 'How will the costs of the program be shared between governments, the private sector, and individual Canadians?' What is clear from the discussion paper is that, while the federal government has not ruled out the possibility of using copayments or deductibles, "any approach to raising revenues should consider whether contributions should be based on ability to pay, the impacts on Canada's economy and competitiveness, as well as the administrative and compliance costs for tax payers and governments." As such, if copayments and deductibles are to be used in a national pharmacare program, it seems likely that they would vary based on considerations such as medical condition, type of drug, and/or socio-economic status.

The federal government has given clues as to what sort of pharmacare program is in mind; however, this should not narrow the view of what is possible or what is best. Various stakeholders must decide what the desired outcomes of national pharmacare are, then design a program that best suits them.

Summary of Narrowing the Options

To begin, the legislative decision point comes down to whether the *Canada Health Act* should be amended to include pharmacare as an insured health service. This would require that a national pharmacare program follow the five principles previously discussed - public administration, comprehensiveness, universality, portability, and accessibility. However, Finance Minister Bill Morneau's comments following Budget 2018 call into question the federal government's commitment to universality and comprehensiveness. This was further reinforced by the recent discussion paper published by the federal Ministers of Finance and Health, which listed several questions for consultation and did not include one concerning any potential amendments to the *Act*. As such, at the IFSD we expect the federal government will be lukewarm to amending the *Act*, and provincial-territorial governments should start preparing for a national pharmacare program operated outside of it.

The current Government of Canada has already established a precedent for introducing a health transfer outside of the *Canada Health Act*, in this case for home care and mental health, with its own requirements and performance criteria. Another take-it-or-leave-it offer of this nature would be difficult for provincial-territorial governments to refuse, particularly if the federal government picks each province off one by one through the creation of bilateral agreements. At the IFSD, we believe that this will be the most likely approach taken by the federal government, allowing them to cap the aggregate level of transfers but still giving them control of the criteria needed for provincial-territorial governments to receive funds so as to meet the Government of Canada's desired objectives.

In the context of these possible outcomes, the demands placed on provinces and territories will undoubtedly need to be in line with the federal funds provided. Indeed, this is even more so the case as the federal government is in a fiscally sustainable position whereas subnational governments as a group are not. And, if comprehensive drug coverage is not on the table due to the Finance Minister's desire for a national pharmacare plan to be "fiscally prudent," the use of an essential medicines or most frequently prescribed list may be the direction the federal government will take. That is assuming the federal government is looking to just 'fill the gaps' in current provincial-territorial coverage, as has been stated by the Finance Minister. The scope of drug coverage may also be a function of the ability of provincial and territorial levels of government to charge copayments and deductibles to help offset part of the cost of administering a national pharmacare program.

As demonstrated, several options must be considered before a national pharmacare program can be agreed to in Canada. The desired outcomes should be decided upon first so that the various structural component options can be pieced together to help best achieve those goals.

CONCLUSION

In conclusion, when the federal government decides to go ahead with a national pharmacare program, the IFSD believes that a drug formulary which is universally provided to all Canadians should form the basis of a national pharmacare plan. Further, a single-payer and single-buyer program will improve the efficiency of the pharmacare program. The bargaining power that a single-buyer holds will account for much of the savings associated with the national pharmacare program.

At a minimum, a national pharmacare program should cover the essential medicines listed on the CLEAN Meds list, many of which are already included in some shape or form in federal-provincial-territorial formularies. But if a limited formulary is agreed upon as the basis for national pharmacare, this should not be considered an end in and of itself, but rather the starting point for a more comprehensive formulary down the road. And any formulary, no matter the level of comprehensiveness at first, should be determined at arm's length from the government and by experts using evidence-based approaches.

Further, the national pharmacare program should be delivered by the provinces and territories, as the administrative capacity and broad constitutional responsibility rests with them. In this context, we believe that a national pharmacare program should be paid for by the federal government through a transfer to provinces and territories. We also believe this transfer should be sufficiently large enough to pay for the bulk of the costs associated with national pharmacare, as the federal government is currently in a much more sustainable fiscal position than are the provinces and territories. A sufficiently large transfer would also reduce the need for cost-sharing mechanisms, such as copayments and deductibles. Assuming the full cost of national pharmacare would not be out of fiscal reach for the federal government, particularly in the context of an essential-medicines or most-frequently-prescribed-drug formulary. However, should the federal government choose to fund universal pharmacare with a comprehensive formulary while also maintaining a stable debt-to-GDP ratio, an increase in the GST of about two percentage points would increase revenues sufficiently to ensure the federal government remains in a fiscally-sustainable position.

At the IFSD, we are broadly supportive of a national pharmacare program that is enabled through legislation outside of the *Canada Health Act*, and therefore funded through a transfer separate from the CHT. This would give the provinces and territories peace of mind by directly tying funding to

services, while at the same time providing to the federal government the opportunity to determine performance requirements. And, while not explicitly saying so, we believe that leaving the *Act* without amendments is the preference of the federal government, as there is precedent for an approach that uses formal agreements instead and there are no questions related to amending the *Act* in the discussion paper from the federal Ministers of Health and Finance. If this is the preferred option of the federal government, we also believe that this transfer should come with performance criteria that need to be met in order for provinces and territories to receive the transfer, as is the case with the current agreement for the home care and mental health transfer. However, the creation of a new act would solidify national drug coverage without an expiry date as would be the case with the aforementioned negotiated agreements.

Regardless of the form that a national pharmacare program takes in Canada, one thing is clear: the time has come for Canada to join other OECD countries that offer pharmacare as part of a single-payer, universal health care system. Federal politicians and Canadian Premiers must seize this historic opportunity to support Canadians' health and well-being from coast to coast to coast.

Endnotes

[1] https://www.ourcommons.ca/

[2] IBID

[3] http://pharmacare2020.ca/

[4] https://www.ncbi.nlm.nih.gov/

[5] http://www.hallfoundation.ca/

[6] http://pharmacare2020.ca/

[7] http://publications.gc.ca/

[8] https://lop.parl.ca/

[9] https://qspace.library.queensu.ca/

[10] IBID

[11] http://laws-lois.justice.gc.ca/

[12] https://sencanada.ca/

[13] https://sencanada.ca/- PAGE 41

[14] https://sencanada.ca/

[15] https://www.cfhi-fcass.ca/

[16] THIS PRINCIPLE ALSO REQUIRES THAT A PERSON MUST BE A RESIDENT OF A PROVINCE OR TERRITORY FOR AT LEAST THREE MONTHS IN ORDER TO QUALIFY FOR COVERAGE IN THAT JURISDICTION.

[17] https://www2.gov.bc.ca/

[18] IBID

[19] http://laws-lois.justice.gc.ca/

[20] https://sencanada.ca/

[21] IBID

[22] http://laws-lois.justice.gc.ca/

[23] https://www.fin.gc.ca/

[24] https://www.fin.gc.ca/

[25] IT SHOULD BE NOTED THAT THE SEPARATE TRANSFER FOR HOME CARE AND MENTAL HEALTH, ANNOUNCED DURING THE RENEGOTIATION OF THE CHT IN THE 2016-17 FISCAL YEAR, IS NOT INCLUDED IN THESE AMOUNTS.

[26] https://www.canada.ca/

[27] http://www.ourcommons.ca/

28 IBID - PAGE 2

29 IBID - PAGE 68

30 IBID

31 https://www.canada.ca/

32 http://www.pmprb-cepmb.gc.ca/

33 THE CLASSIFICATION SYSTEM USED IS THE ATC-5 CLASSIFICATION. ACCORDING TO THE WORLD HEALTH ORGANIZATION, "THE ATC CLASSIFICATION SYSTEM DIVIDES THE DRUGS INTO DIFFERENT GROUPS ACCORDING TO THE ORGAN OR SYSTEM ON WHICH THEY ACT AND ACCORDING TO THEIR CHEMICAL, PHARMACOLOGICAL AND THERAPEUTIC PROPERTIES. DRUGS ARE CLASSIFIED IN GROUPS AT FIVE DIFFERENT LEVELS." THIS CLASSIFICATION IS FURTHER REFINED BY DRUG IDENTIFICATION NUMBER (DIN), WHICH "IS A COMPUTER-GENERATED EIGHT-DIGIT NUMBER ASSIGNED BY HEALTH CANADA TO A DRUG PRODUCT PRIOR TO BEING MARKETED IN CANADA. IT UNIQUELY IDENTIFIES ALL DRUG PRODUCTS SOLD IN A DOSAGE FORM IN CANADA AND IS LOCATED ON THE LABEL OF PRESCRIPTION AND OVER-THE-COUNTER DRUG PRODUCTS THAT HAVE BEEN EVALUATED AND AUTHORIZED FOR SALE IN CANADA."

34 http://www.cmaj.ca/

35 http://cleanmeds.ca/

36 http://www.forces.gc.ca/

37 http://www.veterans.gc.ca/

38 http://www.cmaj.ca/

39 https://onlinelibrary.wiley.com/

40 NETHERLANDS HEALTHCARE SECTOR ORGANIZATION, MANAGEMENT AND PAYMENT SYSTEMS HANDBOOK VOLUME 1 STRATEGIC INFORMATION AND BASIC LAWS, INTERNATIONAL BUSINESS PUBLICATIONS, PAGE 52

41 https://onlinelibrary.wiley.com/

42 IBID

43 IBID

44 IBID

45 http://www.cmaj.ca/

46 IBID

47 http://www.pbo-dpb.gc.ca/

48 http://www.ifsd.ca/

49 https://www.ourcommons.ca/

50 https://sencanada.ca/

51 https://www.cdhowe.org/

52 http://www.ourcommons.ca/

53 IBID

54 https://www.canada.ca/

[55] IBID

[56] https://www.canada.ca/

[57] https://www.canada.ca/

[58] https://nursesunions.ca/

[59] https://www.cdhowe.org/

[60] http://www.cmaj.ca/

[61] https://www.cma.ca/

[62] https://www.canada.ca/

[63] https://lop.parl.ca/

[64] https://www.canada.ca/

[65] https://nursesunions.ca/

[66] http://www.cmaj.ca/

[67] https://www.canada.ca/

[68] http://www.pbo-dpb.gc.ca/

[69] http://www.cmaj.ca/

[70] https://nursesunions.ca/

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ANNEX 1
TABLE 5: PROVINCIAL AND TERRITORIAL PUBLIC DRUG PROGRAMS

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
British Columbia	Fair Pharmacare	BC Resident	x	x	30%	0-3% net annual income	2-4% net annual income	
	Permanent Resident of Licensed Residential Care Facilities (Plan B)	Permanent BC resident of licensed residential care facility	x	x	x	x	x	
	Recipients of BC Income Assistance (Plan C)	BC resident on income assistance	x	x	x	x	x	
	Cystic Fibrosis (Plan D) *follows cystic fibrosis (CF) formulary	BC resident with CF	x	x	x	x	x	
	Children in the At Home Program (Plan F)	BC child in the At Home Program	x	x	x	x	x	
	Psychiatric Medications (Plan G)	BC resident with clinical and financial need	x	x	x	x	x	
	BC Palliative Care Drug Plan (Plan P)	BC resident in end-of-life care	x	x	x	x	x	
	First Nations Health Benefits (Plan W) *funded by FN Health Authority	First Nations person in BC	x	x	x	x	x	
Alberta	Non-Group Coverage	AB resident	up to $63.50/ person or $118/family	30% to a max of $25/pre-scription	x	$50 yearly	x	
	Coverage for Seniors	AB resident over 65	x	30% to a max of $25/pre-scription	x	x	x	
	Palliative Coverafe	AB resident in end-of-life care	x	30% to a max of $25/pre-scription	x	x	Lifetime maximum of $1,000.00	
	Outpatient Cancer Drug Benefit Program	AB resident with cancer	x	x	x	x	x	
	Specialized High Cost Drug Program	AB resident with high drug cost	x	x	x	x	x	
	Disease Control and Prevention Program	AB resident with tu-berculosis or sexually transmitted disease	x	x	x	x	x	

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
Saskatchewan	Saskatchewan Drug Plan	Enrolled in supplementary health program Receiving special benefits from the SK Aids to Independent Living program Qualifying for palliative care	x	up to $2	x	x	x	
	Senior's Drug Plan	SK resident over 65	x	up to $25	x	x	x	
	Children's Drug Plan	SK child under 15	x	up to $25	x	x	x	
Manitoba	Manitoba Pharmacare Program	MB resident	x	x	x	up to 6.98% of annual income	x	
Ontario	Ontario Drug Benefit	ON resident over 65 Enrolled in Ontario Disability Support Program ON resident in long-term care or homecare ON resident enrolled in Ontario Works	x	up to $6.11	x	up to $100	x	
	OHIP+	ON resident under 25	x	x	x	x	x	
	Trillium Drug Program	ON residents with high drug costs	x	$2	x	up to 4% of household income; varies with income	x	
New Brunswick	New Brunswick Drug Plan	NB resident eligible for medicare	up to $2,000 yearly	30% to a max of $30 per prescription	x	x	x	

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
New Brunswick (cont'd)	New Brunswick Prescription Drug Program	NB resident over 65	x	$9.05 per prescription to a max of $500	x	x	x	
		NB resident in nursing home	x	x	x	x	x	
		NB adult in special care home	x	$4.00 per prescription up to a max of $250	x	x	x	
		NB social development client	x	$4.00 per prescription up to a max of $250 per family	x	x	x	
		NB child in care of the Minister of Social Development and/or special needs child	x	x	x	x	x	
		NB resident with cystic fibrosis	$50 annually	20% to a max of $20 per prescription	x	x	$500 per family per year	
		NB resident with multiple sclerosis	$50 annually	up to 76%; varies with income	x	x	x	
		NB resident who has received bone marrow or solid organ transplant	$50 annually	20% to a max of $20 per prescription	x	x	$500 per family per year	
		NB resident uner 19 with growth hormone deficiency	$50 annually	20% to a max of $20 per prescription	x	x	$500 per family per year	
		NB resident with HIV/AIDS	$50 annually	20% to a max of $20 per prescription	x	x	$500 per family per year	
Quebec	Le régime public d'assurance médicaments (Public Prescription Drug Insurance Plan)	QC resident ineligible for private plan or QC resident over 65	up to $667 yearly	x	34.8% of the cost of the prescription minus deductible	$19.45 monthly	$88.83 monthly ($52.65 for seniors)	

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
Nova Scotia	Seniors' Pharmacare Program	NS resident over 65	up to $424 yearly	20% per prescription to a max of $382 yearly				
	Family Pharmacare Program	NS resident	x	20% of prescription		up to 20% of income; varies with income	up to 25% of income; varies with income	
	Drug Assistance for Cancer Patients	NS resident with cancer and income below $25,500	x	x	x	x	x	
	Palliative Care Drug Program	NS resident in end-of-life care	x	x	x	x	x	
	Department of Communiver Servies Pharmacare Benefits	NS resident in Disability Support Program NS child in care of child welfare NS resident with low income	x	x	x	x	x	See [a] below.
[a] helps eligible beneficaries with the cost of certain prescribed drugs. Benefits indicated in the NS formulary.								
Prince Edward Island	Generic Drug Program	PE resident under 65 without insurance	x	up to $19.95 per prescription	x	x	x	
	Seniors' Drug Program	PE resident over 65	x	$8.25 + $7.69 of the pharmacy fee	x	x	x	
	AIDS/HIV Drug Program	PE resident with AIDS/HIV	x	x	x	x	x	
	Catastrophic Drug Program	PE resident with high drug costs	x	x	x	between 3% and 12% of annual income	x	
	Children in Care Drug Program	PE resident in temporary or permanent custody of the Director of Child Welfare	x	x	x	x	x	
	Community Mental Health Drug Progrm	PE long-term psychiatric patient	x	x	x	x	x	
	Cystic Fibrosis Drug Program	PE resident with CF	x	x	x	x	x	

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
Prince Edward Island (cont'd)	Diabetes Drug Program	PE resident with diabetes	x	$11 per prescription	x	x	x	
	Erythropoietin Drug Program	PE resident diagnosed with chronic renal failure or receiving kidney dialysis	x	x	x	x	x	
	Family Health Benefit Drug Program	PE family with at least one child under 25 and annual net household income of less than $24,800, rising per extra child	x	x	x	x	x	
	Financial Assistance Drug Program	PE resident eligible under the Social Assistance Act and Regulations	x	x	x	x	x	
	Growth Hormone Drug Program	PE child with growth hormone deficiency or Turners Syndrome	x	x	x	x	x	
	Hepatitis Drug Program	PE resident diagnosed with hepatitis or in close congtact with someone who has	x	x	x	x	x	
	High Cost Drug Program	PE resident	x	income-based	x	x	x	
	Institutional Pharmacy Program	PE resident in government manor	x	x	x	x	x	
	Meningitis Drug Program	PE resident diagnosed with meningitis	x	x	x	x	x	
	Nursing Home Drug Program	PE resident in nursing home	x	x	x	x	x	
	Nutrition Services Program	PE high-risk pregnant women diagnosed with nutritional deficiency	x	x	x	x	x	
	Phenylketonuria (PKU) Supplement Program	PE resident diagnosed with PKU	x	x	x	x	x	
	Quit Smoking Drug Program	PE resident in smoking cessation program	x	x	x	x	x	See [b] below

[b] programs pays first $75 of approved prescriptions per year.

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
Prince Edward Island (cont'd)	Rabies Vaccine Program	PE resident with exposure to rabies	x	x	x	x	x	
	Sexually Transmitted Disease Drug Program	PE resident diagnosed with sexually transmitted disease	x	x	x	x	x	
	Transplant Anti-Rejection Drug Program	PE resident who has received a bone marrow or solid organ transplant	x	x	x	x	x	
	Tuberculosis Drug Program	PE resident diagnosed with tuberculosis	x	x	x	x	x	
Newfoundland and Labarador	Foundation Plan	NL resident receiving income support	x	x	x	x	x	
	65Plus Plan	NL resident over 65	x	up to $6	x	x	x	
	Access Plan	NL resident with low income	x	x	20% to 70%	x	x	See [c] below
	Assurance Plan	NL resident whose drug costs exceed 5% to 10% of net income; depending on total income	x	x	varies with income	x	x	
	Select Needs Plan	NL resident with cystic fibrosis or growth hormone deficiency	x	x	x	x	x	
[c] varies with family status and income level.								
Northwest Territories	Extended Health Benefits Seniors' Program	NT resident over 60	x	x	x	x	x	
	Specified Disease Conditions Program	NT resident with condition specified on NT health website	x	x	x	x	x	
	Métis Health Benefit Program	NT registered indigenous métis	x	x	x	x	x	
Nunavut	Extended Health Benefits	NU resident with specific condition, without insurance, or over 65	x	x	x	x	x	

Province	Plan Name	Eligibility	Premium	Co-Payment	Co-Insurance	Deductible	Max OOP	Notes
Yukon	Pharmacare and Extended Health Benefits	YK resident over 65 or over 60 and married to resident over 65	x	x	x	x	x	
	Chronic Disease Program	YK resident with chronic disease or disability	x	x	x	x	x	
	Children's Drug and Optical Program	YK low-income family with children 18 and under	x	x	x	up to $250 per child, up to $500 per family	x	

Sources: British Columbia Ministry of Health, Alberta Health, Saskatchewa Ministry of Health, Manitoba Health, Seniors and Active Living, Ontario Ministry of Health and Long-Term Care, Ministère de la Santé et des Services sociaux, New Brunswick Department of Health, Nova Scotia Department of Health and Wellness, Prince Edward Island Health and Wellness, Newfoundland and Labrador Health and Community Services, Northwest Territories Health and Social Services, Nunavut Department of Health, Yukon Health and Social Services, compiled by the Institute of Fiscal Studies and Democracy.

Notes: Accurant as of June 30, 2018. Ontario has announced changes to OHIP+ since.

ANNEX 2
TABLE 6: CLEAN Meds List vs FORMULARIES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Abacavir	SA	YES	SA	NO	YES	YES	YES	NO	YES	YES	YES	YES	YES
Acetaminophen	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES
Acetylsalicylic Acid	YES	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES
Adalimumab	SA	NO	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA
Alendronate	YES	NO	SA	YES	SA	YES	YES	YES	YES	YES	YES	YES	YES
Allopurinol	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Amiodarone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Amlodipine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Amoxicillin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Amoxicillin/Clavulanic Acid	YES	SA	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Atomoxetine	SA	NO	SA	YES	YES	SA	SA	YES	NO	NO	SA	SA	SA
Atorvastatin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Azathioprine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Azithromycin	YES	SA	YES	YES	YES	YES	YES	SA	SA	YES	YES	YES	YES
Baclofen	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Beclomethasone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Benzoyl Peroxide	YES	YES	YES	COMBO	YES	NO	NO	NO	NO	YES	YES	YES	YES
Benztropine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Betamethasone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Bevacizumab	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	SA	NO
Bisoprolol	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Budesonide	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Candesartan	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Carbamazepine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Cephalexin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Cetirizine	NO	NO	NO	NO	YES	NO	NO	SA	YES	YES	YES	NO	YES
Chlorthalidone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Ciprofloxacin	SA	SA	SA	SA	YES	YES	SA	SA	SA	YES	YES	YES	YES
Clarithromycin	YES	SA	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Clindamycin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Clopidogrel	YES	YES	SA	YES	SA	SA	YES	YES	YES	YES	YES	YES	YES
Clotrimazole	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Cloxacillin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Clozapine	NO	YES	SA	YES	YES	YES	YES	NO	SA	SA	YES	YES	YES
Conjugated Estrogens	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Dabigatran	SA	NO	SA	SA	SA	SA	SA	SA	SA	SA	SA	NO	SA
Dexamethasone	YES	YES	YES	YES	YES	SA	YES	YES	SA	YES	YES	YES	YES
Diltiazem	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Dolutegravir	SA	NO	SA	NO	NO	YES	YES	NO	YES	SA	YES	SA	YES
Domperidone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Donepezil	SA	NO	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA
Doxycycline	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Efavirenz	SA	YES	SA	NO	YES	YES	YES	NO	YES	YES	YES	YES	YES
Eletriptan	NO	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	NO
Emtricitabine	SA	NO	COMBO	NO	NO	YES	COMBO	NO	COMBO	SA	COMBO	SA	COMBO
Epinephrine	YES	YES	YES	YES	YES	YES	YES	YES	SA	YES	YES	SA	YES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Estradiol	YES	SA	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES
Ethinyl Estradiol/Levonorgestrel	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES
Ferrous Fumarate	YES	NO	NO	SA	NO	NO	YES	NO	NO	YES	YES	YES	YES
Finasteride	SA	SA	YES	YES	SA	YES	YES	YES	YES	YES	SA	YES	SA
Fluconazole	YES	SA	YES	YES	SA	SA	YES	YES	SA	YES	YES	YES	YES
Fluoxetine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Fluticasone	YES	YES	YES	YES	YES	YES	YES	NO	SA	SA	YES	YES	YES
Folic Acid	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Furosemide	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Fusidic Acid	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Gabapentin	YES	YES	YES	YES	YES	YES	YES	SA	YES	SA	YES	YES	YES
Gliclazide	YES	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES	YES
Haloperidol	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Hydrocortisone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Hydroxychloroquine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Ibuprofen	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Insulin, Long Acting	YES	NO	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES
Insulin, Short Acting	YES	YES	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES
Ipratropium	YES	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES	YES
Labetalol	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES
Lamivudine	SA	YES	SA	SA	YES	YES	YES	SA	YES	YES	YES	YES	YES
Latanoprost	SA	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Levodopa/Carbidopa	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Levofloxacin	SA	SA	SA	SA	YES	YES	SA	SA	SA	SA	YES	YES	YES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Levonorgestrel	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	NO	YES
Levothyroxine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Lithium	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Loperamide	SA	NO	YES	YES	SA	YES	YES	YES	YES	NO	YES	NO	YES
Medroxyprogesterone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Metformin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Methimazole	YES	NO	YES	YES	NO	NO	NO	YES	YES	YES	YES	YES	YES
Methotrexate	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Methylprednisolone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Metoclopramide	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Metronidazole	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Mupirocin	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Naltrexone	SA	NO	SA	NO	SA	YES	SA	SA	SA	NO	YES	YES	YES
Naproxen	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Nicotine (transdermal patch or gum)	NO	NO	NO	NO	NO	NO	SA	NO	YES	YES	YES	NO	YES
Nitrofurantoin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Nitroglycerin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Nortriptyline	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Nystatin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Olopatadine	NO	NO	NO	NO	YES	NO	YES	YES	NO	YES	YES	YES	YES
Pantoprazole	YES	YES	YES	YES	SA	YES	YES	YES	SA	YES	YES	YES	YES
Permethrin	YES	NO	YES	YES	YES	YES	YES	NO	YES	YES	YES	NO	YES
Phenytoin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Pilocarpine	YES	YES	YES	YES	YES	YES	SA	SA	SA	YES	YES	YES	YES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Polyethylene Glycol 3350	YES	NO	NO	SA	YES	SA	NO	NO	NO	YES	YES	NO	YES
Polymyxin B	YES	YES	YES	COMBO	YES	YES	COMBO	NO	YES	NO	COMBO	COMBO	COMBO
Potassium	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Pravastatin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Prednisone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Propylthiouracil	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Ramipril	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Ranitidine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Risperidone	YES	YES	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES
Rivaroxaban	SA	NO	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA	SA
Salbutamol	YES	YES	YES	YES	YES	SA	YES	YES	YES	YES	YES	YES	YES
Salicylic Acid	NO	NO	NO	SA	NO	YES	SA	COMBO	COMBO	NO	YES	NO	YES
Salmeterol	SA	YES	SA	YES	SA	YES	SA	SA	SA	SA	SA	SA	SA
Senna	NO	NO	NO	SA	YES	SA	NO	YES	YES	YES	YES	NO	YES
Sertraline	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Spironolactone	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Sulfamethoxazole/Trimethoprim	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Sulfasalazine	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Tadalafil	SA	NO	SA	NO	YES	SA	NO	NO	NO	NO	SA	SA	SA
Tamsulosin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Tenofovir Disoproxil Fumarate	SA	NO	SA	SA	SA	YES	SA	SA	YES	SA	SA	SA	SA
Thiamine	NO	NO	YES	YES	YES	YES	NO	YES	NO	YES	YES	NO	YES
Tiotropium	YES	NO	SA	YES	SA	YES	SA	SA	SA	SA	SA	SA	SA
Tranexamic Acid	SA	YES	YES	YES	YES	YES	YES	SA	NO	YES	YES	YES	YES

Essential Drug	ON	MB	SK	AB	BC	QC	NB	NS	PE	NL	NT	YK	NU
Tretinoin	SA	YES	YES	SA	SA	SA	YES	SA	SA	YES	YES	NO	YES
Trimethoprim	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Urea	NO	NO	NO	COMBO	NO	YES	COMB	NO	YES	YES	COMBO	NO	COMBO
Vaginal Ring Eluting Etonogestrel + Ethinyl Estradiol	NO	NO	NO	NO	YES	YES	YES	YES	NO	YES	YES	NO	YES
Valacyclovir	SA	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Valproic Acid	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Varenicline	SA	YES	YES	SA	YES	YES	SA	NO	SA	YES	YES	YES	YES
Vitamin B12	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Vitamin D	NO	NO	NO	SA	YES	YES	YES	NO	YES	YES	YES	YES	YES
Warfarin	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

Notes: Yes = Drug is covered; No = Drug is not covered; SA = Special Authorization; Combo = Drug is only available in combination with other medicines. Special Authorization includes any drugs for which beneficiaries must meet additional criteria or submit a supplementary request to receive. It includes any drugs denoted as “exceptional” or “limited use.”

PATENTED MEDICINES PRICES REVIEW BOARD

The Patented Medicines Prices Review Board (PMPRB) was created in 1987 under the Patent Act, the PMPRB is a federal government agency that regulates the Canadian pharmaceutical industry. The PMPRB's mandate is to protect Canadian consumers by ensuring that the prices of patented medicines sold in Canada are not excessive. It does this by reviewing the prices of patented drugs and holding public hearings if the prices are deemed excessive.

The Patent Act requires patent-holders to submit price and sales information for all patented products upon introduction, and on a bi-annual basis thereafter. The PMPRB's regulatory process involves a two-step review—a scientific review assessing the therapeutic benefit of a new product, followed by a price review.

The level of therapeutic improvement is used to set a new drug's ceiling price: more effective medicines are allowed to be priced higher. The price review then relies primarily on the following guidelines to determine whether a product is excessively priced:

- the prices at which the product has been sold in the relevant market;
- the prices of other medicines in the same therapeutic class;
- the prices of the product in other countries; and
- changes in the Consumer Price Index.

The PMPRB investigates products if their price appears to be excessive. If the investigation shows that the price violates the Compendium of Policies, Guidelines and Procedures, this could lead to a written compliance commitment made by the patentee, or a public hearing resulting in an order to reduce the price and to offset the higher revenues received.

Canada has some of the highest prices and per capita spending for medicines in the world in part because of flaws with the PMPRB. The use of countries with high drug prices as a benchmark is a contributing factor to Canada's high prices. This was intended to attract higher levels of pharmaceutical investment but has not been effective. The percentage of sales drug companies reinvest in Canadian R&D has dropped to a record low of 4.4%, well below the minimum 10% promised by industry and average 20% invested in comparable nations.

Another issue is that the PMPRB bases its cost comparisons off of public list prices, which are significantly higher than the drugs' confidential, true costs. This is due to the information asymmetry between the pharmaceutical companies and their clients; confidential rebates are negotiated individually by federal, provincial and private drug plans. This lack of information can easily lead to regional price differences.

PAN-CANADIAN PHARMACEUTICAL ALLIANCE

The pan-Canadian Pharmaceutical Alliance (pCPA). The pCPA is an informal alliance that combines the bargaining power of Canadian provincial drug plans to negotiate lower drug prices for government programs. The pCPA was created by Canada's premiers at the Council of the Federation in 2010, and the federal government joined the alliance in 2016.

Once the pCPA has negotiated a price on behalf of all participating drug plans, the manufacturers must

negotiate a product list agreement (PLA) with each individual drug plan for their product to be covered. While all members participate in the bargaining process, there is no guarantee that a drug will be covered by all participating pCPA plans.

As of May 31, 2018, the status of pCPA negotiations are as follows:

- 215 joint negotiations complete;
- 25 agreements failed;
- 42 negotiations currently underway; and
- 59 products chosen not to negotiate collectively.

With a universal, national and comprehensive pharmacare formulary, the pCPA will still have a valuable position within the new environment. The federal government and all provinces and territories will still bear the cost burden of the drugs covered on the formulary and bulk purchasing will account for much of the savings associated with pharmacare.

According to PDCI Market Access, the pCPA negotiates confidential prices for all jurisdictions of public plans. They suggest that the pCPA already achieves the lowest prices for drugs and renegotiates prices if markets have changed, such as the introduction of new generic drugs.[a]

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[a] http://www.pdci.ca/