The Liberal Party of Canada's Proposal for Nationwide Universal Pharmacare: Informing the Path Forward Via International Comparison

SAPNA WADHAWAN

Supervisor's Name: Dr. Dennis Raphael

Advisor's Name: Dr. Claudia Chaufan

Supervisor's Signature: _____

Date Approved: November 12, 2021

Advisor's Signature: Claudia Chaufan, MD, PhD

Digitally signed by Claudia Chaufan, MD, PhD
CN=Claudia Chaufan, MD, PhD
C=CA - CANADA
O=York University
E=cchaufan@yorku.ca
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York University

Toronto, Ontario M3J 1P3

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Abstract

In 2019, the Liberal Party of Canada (LPC) tabled the most recent proposal (Hoskins Report) for nationwide Pharmacare. It made sixty recommendations on how to achieve universal drug coverage in Canada. Since the 1943 draft proposal for public health insurance, several periodic proposals for nationwide Pharmacare have been put forward at the federal level. A narrative review of these proposals established nationwide Pharmacare is *once again* on the table federally. To inform the path forward, this study compared the Canadian approach to prescription drug coverage with that of the United Kingdom (UK). Canada and the UK were compared in three clusters: (a) the levels and sources of expenditures on prescription drugs; (b) the levels and distribution of pharmaceutical insurance associated with prescription drug spending; and (c) the health outcomes "produced." Recommendations were then provided for implementation of nationwide Pharmacare. I argue that a rapid approach is needed by the federal government to implement the service. The steps taken towards a Pharmacare inclusive Medicare system must be fast-tracked. This type of system is observed to be the norm in high income countries. Several findings indicated poor trends in health system performance and production of health inequalities under the current system for prescription drug coverage. The Hoskins Report concretely places Pharmacare on the political agenda, creating a window of opportunity for the federal government to employ a rapid approach.

Table of Contents

Canadian Medicare Lacks Pharmacare

The purpose of my research is to inform the path forward for nationwide Pharmacare in Canada by comparing the Canadian approach to prescription drug coverage with that of the United Kingdom (UK). I compare Canada and the UK's approach in three clusters: (a) the levels and sources of expenditures on prescription drugs; (b) the levels and distribution of pharmaceutical insurance associated with prescription drug spending; and (c) the health outcomes "produced." I then provide recommendations based on this analysis for implementation of Pharmacare in Canada.

A nationwide universal program for pharmaceutical insurance, or 'Pharmacare' is not a feature of Canada's public health insurance system and makes Canada the only mature welfare state to lack broad coverage of medicines (Boothe, 2013). Comparatively, the United Kingdom and Australia are similar welfare states that have successfully adopted nationwide pharmaceutical insurance (Boothe, 2013). Welfare states operate in different ways to foster the well-being of their citizens (Coburn, 2010). In different nations or societies, the welfare regime may directly provide for the well-being of their citizens or counteract any market failures to do so (Coburn, 2010). Canada is typically described as a liberal welfare regime. Liberal welfare regimes focus their welfare measures to the poor (Coburn, 2010). Individuals who do not meet the criteria for welfare programs in liberal welfare states have little to no benefits (Coburn, 2010).

In Canada, once a patient is given a prescription to fill by their doctor, its universal public health insurance ends (Morgan & Daw, 2012). Canada's public health insurance, interchangeably known as 'Medicare' covers the following services for each Canadian: medically necessary hospital care, diagnostic tests, and physician services (Morgan & Daw, 2012). These services are

covered irrespective of age, income or province of residence (Morgan & Daw, 2012). At a basic level, the system considers access to healthcare should be based entirely on need and that all members of society share the cost of care (Morgan & Daw, 2012). Provincial governments are responsible for the delivery of health care in Canada. To receive a full federal cash contribution (Canada Health Transfer) each province must meet the criteria and conditions (universal coverage, comprehensiveness, public administration, transferability, accessibility) set under the *Canada Health Act* (*CHA*). The *CHA* is Medicare's legislative blueprint and does not require provinces to deliver universal coverage for prescription drugs outside of hospitals (Flood, 2018). Yet, most provincial governments have chosen to cover vulnerable populations such as: the very poor, the elderly, and people facing catastrophic costs (Flood, 2018). The rest of the population is left to cover the cost of prescription drugs either 'out of pocket' or through private insurance arrangements. This has resulted in a system similar to the deficiencies of the United States' poorly performing health care system (Flood, 2018). Law et al (2018) report: approximately 58 percent of Canadians depend on expensive employer-based private insurance; vulnerable populations rely on a patchwork of public programs; and roughly 20 percent of Canadians do not have any prescription drug coverage.

A number of periodic proposals for nationwide Pharmacare have been put forward at the federal level. Strikingly, the original federal proposal for public health insurance considered in the late 1940s included pharmaceuticals (Boothe, 2012; Jacobzone, 2000). In 1964, the Royal Commission on Health Services' (Hall Commission) report argued the next frontier of Canadian Medicare should be prescription drug insurance (Pharmacare) (Canada,1964). The Hall Commission was followed by various proposals for nationwide Pharmacare. The most recent proposal, *A prescription for Canada: Achieving Pharamcare for All* (hereinafter the Hoskins

Report) was made public in June 2019. It makes sixty recommendations on how to achieve universal drug coverage in Canada. This proposal appears on behalf of the Liberal Party of Canada (LPC) and indicates that a nationwide universal Pharmacare program is once again on the table—*federally*.

The Hoskins Report demonstrated the UK's public health insurance scheme covers the cost of prescription drugs for their citizens without deductibles and with limited or no copayments for eligible prescription drugs (Government of Canada, 2019). Also, the health system in the UK covers the cost of prescription drugs for their citizens while spending less of their total GDP on health care than Canada. Further, the UK shares key country characteristics with Canada such as: English-speaking, liberal welfare regime, and member of the OECD with a universal public health system. The UK experience for delivering prescription drug coverage was a strong comparator for the Canadian approach to prescription drug coverage and could richly inform the path forward on the recent proposal for nationwide Pharmacare by the LPC. As a result, the overarching goal of my research is to see what messages can be found to inform the path forward regarding the LPC's proposal for nationwide Pharmacare. To locate these messages, I compare the Canadian approach to prescription drug coverage with that of the United Kingdom (UK). I will compare Canada and the UK in three clusters: (a) the levels and sources of expenditures on prescription drugs; (b) the levels and distribution of pharmaceutical insurance associated with prescription drug spending; and (c) the health outcomes "produced."

First, I present a review of the federal proposals for Pharmacare in Canada. My review ranges from the 1943 draft proposal for public health insurance to the 2019 Hoskins Report. This review establishes that nationwide Pharmacare is once again on the table federally. Second, I detail the present-day Canadian and UK approach to prescription drug coverage. Third, I

compare and contrast the three clusters mentioned above for Canada and the UK. Finally, based on my comparison, I present any messages that can inform the path forward on the LPC's proposal for nationwide Pharmacare.

Federal Proposals for Nationwide Pharmacare

The original proposals for Canadian public health insurance included medicines as part of a comprehensive health program. An incremental approach to health policy was adopted early on and nationwide hospital insurance was not achieved until 1957 (a 14-year interval from when the draft legislation for public health insurance was considered by the federal government). Later in 1966, the federal and provincial governments reached an agreement for nationwide medical insurance (a 9-year interval from when nationwide hospital insurance was established). The 1964 Hall Commission, which was the catalyst for the *Medical Care Act* of 1966 (establishment of national standards for nationwide medical insurance), declared the next frontier of Canadian Medicare should be prescription drug insurance. Since this recommendation many proposals for nationwide Pharmacare have followed:

1. Drug Price Program (1971-1972);
2. National Forum on Health (1994-1997);
3. Kirby Report (2002);
4. Romanow Report (2002);
5. Hoskins Report (2019).

Below I chronologically review the periodic proposals for nationwide Pharmacare at the federal level. I reveal that a nationwide universal Pharmacare program is once again on the table federally.

Draft Legislation for Public Health Insurance

The draft legislation for a national health insurance program, considered by the federal cabinet in January of 1943, was based on two expert reports (MacDougall, 2009, p.299). These

reports called for a comprehensive health program which included pharmaceuticals (also referred to prescription drugs or medicines in this paper) (Advisory Committee on Health Insurance, Canada, 1943; Marsh, 1943; Taylor, 2009). The draft legislation lacked support from Prime Minister Mackenzie King and faced opposition from the finance department (MacDougall, 2009, p.302). As a result, the proposal submitted to the Dominion-Provincial Conference on Reconstruction (gathering of Canada's provincial premiers with federal prime minister [also called First Ministers Conferences] [Bothwell, 2014]) in 1945, was cautious in its scope (Boothe, 2013).

Initial Proposals for Public Health Insurance

The federal government proposed the comprehensive health service to provinces in 1945 (Boothe, 2013). The provinces would "have to take, in its entirety, and in fixed order, within a certain time limit" the proposed service (LAC, 1949b). Additionally, the federal government admitted the plan should be flexible and "capable of being introduced in any province by several stages" (Canada, 1945; Morgan & Daw, 2012). The full range of health services was on the table at this time (Boothe, 2013). Brandt et al (2018) note, "Canada's system of universal health insurance was not supposed to exclude prescription drugs" (p.2). Interviews with policy advisors support this interpretation and have consistently cited "the early assumption that healthcare would proceed in stages" (Boothe, 2013). Boothe (2012) explains, an incremental approach to health policy was adopted at this time. Canada did not have the conditions for a radical approach in the immediate postwar period, and for that reason, nationwide hospital insurance was not achieved until 1957 (Boothe, 2012). Specifically, the *Hospital Insurance and Diagnostic Services Act* of 1957 established the national standards for universal hospital insurance (Morgan & Daw, 2012). In 1966, a federal-provincial agreement was reached for medical insurance (the

national standards were established under the *Medical Care Act* of 1966) and provinces implemented the program between the years 1966 and 1972 (Boothe, 2012; Morgan & Daw, 2012).

Royal Commission on Health Services (Hall Commission)

The catalyst for the *Medical Care Act* of 1966 was the Hall Commission (Canada, 1964). The Hall Commission recommended that Pharmacare should follow after physician services were insured (Canada, 1964). To establish a prescription drug program, the commission recommended federal and provincial governments share the cost 50/50 and charge $1.00 per prescription, but this recommendation was not implemented (Canada 1964; Adam & Smith, 2017). Expenditures on pharmaceuticals in the mid-1960s were low compared to present day numbers (Lexchin, 2016). However, with the Post-World War II therapeutic revolution, the use and cost of medicines was increasing (Canada, 1963; Lexchin, 2016). The Hall Commission's report focusing on prescription medicines, detailed the challenges "of establishing a drug benefit program in the face of excessive patient demand, excessive prescribing, too many repeat prescriptions, [and] the lack of historic plateau or benchmark of use or average prescription price." (Morgan & Daw, p.16, 2012; Lexchin, p.158, 2016). Based on these remarks, the report recommended Pharmacare should be delayed until drug spending had stabilized (Lexchin, 2016).

Pharmacare Policy Development

Although, the expansion of Medicare into Pharmacare was the next logical step in health care coverage, a piecemeal approach was taken towards policy development (Lexchin, 2016; Boothe, 2013). The 'pace of change' deposited certain mechanisms which impacted the policy development for Pharmacare (Boothe, 2013, p.446). Boothe (2013) states, "a lack of consensus on big policy ideas contributes to a slow process of policy development, and this process in turn

reinforces limited policy ideas" (p.466). Pharmacare became lodged as an 'extra' in the minds of politicians, policy leaders, and after some time, the public (Boothe, 2013; Lexchin, 2016). The vision for implementing this type of national policy became increasingly difficult overtime (Boothe, 2013; Lexchin, 2016).

Drug Price Program

To describe the drug price program in-depth, I rely on Katherine Boothe's recent monograph which contrasts the development of national prescription medication programs in Australia and the United Kingdom with the failure to do so in Canada (Boothe, 2015). Specifically, she has reviewed the archival memoranda regarding the program (Boothe, 2015). Between 1971 and 1972, health ministers developed a proposal for a drug price program which would extend Medicare to prescription drugs (LAC, 1971; as cited in Boothe, 2013). This proposal, which would "reduce the price of medicines, fill the gap in the provision of health care, and rationalize the use of existing public services" was a principled policy choice by the bureaucratic authors (Boothe, 2013, p.433). Boothe (2013) references a draft memo from the Department of National Health and Welfare (DHW) named "Some Social Reasons for Pharmacare." The memo (LAC, n.d.) argues, "it does not make much sense to pay a physician under Medicare to examine and prescribe for her patient if the patient is unable to [afford the medicine]." Also, it recommends that benefits should be launched on a universal basis since the federal government has the capacity (most bargaining power over prices) to act as a single purchaser of medicines (LAC, 1972; as cited in Boothe, 2013, p.433). These recommendations were not considered by the cabinet ministers at the time (Boothe, 2013). Their main concern was containing the cost of pharmaceuticals to the federal government (Boothe, 2013).

The focus of the cabinet became a ‘staged program' which would begin with providing drug coverage to elderly and later on children, and eventually vulnerable groups (Boothe, 2013). Boothe (2013) explains, “the result was that Pharmacare proposals were not debated as a principled extension of Medicare, but rather as one of a number of unrelated options for assisting elderly Canadians” (p.434-435). The 1972 drug price program quietly failed, no federal legislation on the subject of Pharmacare followed, and pharmaceutical policy at the federal level proceeded to manage prices and patents (Boothe, 2013; Morgan & Daw, 2012).

Provincial Drug Insurance Programs

Without a national standard to use as a model, each province developed its own prescription drug insurance program throughout the 1970s and 1980s (Mogan & Daw, 2012). These programs were mainly subsidy programs and targeted the most vulnerable groups (social assistance recipients and elderly) (Grootendorst, 2002, from Morgan & Daw, 2012). Some provincial (ex. British Columbia) drug benefits emerged from government departments that were responsible for income assistance instead of healthcare (British Columbia, 2004; from Morgan & Daw 2012). Interestingly, Saskatchewan developed a comprehensive and universal program which operated between 1975 and 1987 (Saskatchewan Health, 2010).

National Forum on Health

Prescription drug insurance returned to the federal policy agenda in 1997 with the National Forum on Health (NFH) (Boothe, 2012). The NFH was struck in 1994 and reported in 1997 (CMA, 2016). First dollar coverage of prescription medicines was recommended in a NFH working group paper on pharmaceutical policy (Government of Canada, 2004). In addition, the paper stated “over time we propose to shift private funding on prescribed pharmaceuticals (estimated at $3.6 billion in 1994) to public funding” (Government of Canada, 2004). This

recommendation was included in the final report stating: “the absorption of currently operating plans by a public system may involve transfer of funding sources as well as administrative apparatus” (NFH, 1998).

The CMA (2016) places the 1994 prescription drug expenditure noted by the NFH in today’s context. The $3.6 billion in 1994 would cost $9.5 billion in 2014 using the Bank of Canada’s inflation calculator (Government of Canada, 2004; CMA, 2016). Actual spending in 2014 was $28.7 billion assessed by the Canadian Institute for Health Information (CIHI, 2020). This total is 203% above the spending level in 1994 (CMA, 2016). In comparison, over the same time period (1994-2014) the population growth was 23% in Canada (CMA, 2016). The annual average on prescription drug spending was 7.7% over the same time period whereas since 2010 the average was just 1.6% (CIHI, 2020).

Berry (1965) demonstrates a transfer from private to public funding is not unprecedented. The study *Voluntary Medical Insurance and Prepayment* was prepared for the Hall Commission and estimated 9.6 million Canadians which represents 53% of the total population possessed some type “of not-for-profit or commercial insurance coverage for medical and/or surgical services in 1961” (Berry, 1965; CMA, 2016, p.6). These plans were all displaced as the provinces joined Medicare with the passage of the *Medical Care Act* in 1966 (CMA, 2016). Markedly, this shift in funding did not happen overnight but it did move swiftly (CMA, 2016).

Speech from the Throne 1997

A speech from the throne followed from the NFH report in 1997. By definition, a speech from the throne, which is given at the beginning of a new session of Parliament, discloses the work ministers have proposed for the given session to the Senate and House of Commons (Stewart, 2013). The speech detailed that the government was committed to “develop a national plan,

timetable, and a fiscal framework for providing Canadians with better access to medically necessary drugs" (Parliament of Canada, 1997). This was the only information that was made public and nothing further was added (Adams & Smith, 2017). Contrariwise, Quebec launched its own universal prescription drug plan in 1997 which mandated that all Quebec residents to have private or public prescription drug coverage (Adams & Smith, 2017).

National Studies Tackle Pharmacare 2001 – 2002

Subsequent to the NFH, two national studies were approved and made calls for nationwide Pharmacare (Morgan & Daw, 2012). Notably, federal legislation did not follow from the NFH recommendations detailed in the section above. In March 2001, the Senate study on the condition of Canada's health care system was authorized and chaired by Michael Kirby (Adams & Smith, 2017). In April 2001, the Commission on the Future of Health Care in Canada was approved and led by Roy Romanow (Adams & Smith, 2017). Final reports of these studies were presented in 2002. Both studies recommended the federal government become involved in reimbursing 'catastrophic' prescription drug expenditures (Adams & Smith, 2017). Reimbursement would require meeting a certain threshold relative to household income.

The main focus of these two reports was to close the regional gaps in catastrophic prescription drug coverage (Morgan & Daw, 2012). Specifically, 'catastrophic prescription drug coverage' refers to a benefit that typically protects individuals from prescription drug expenses that place their financial security at risk or creates "undue financial hardship" (Fraser & Shillington, 2005; as cited in Phillips, 2016). A fixed dollar figure, percentage of personal, or family incomes is used to determine the degree of hardship (Health Council of Canada, 2005; as cited in Phillips, 2016). At this time, catastrophic prescription drug coverage was available in all provinces except for Atlantic Canada (Morgan & Daw, 2012). Overall, *minimum* standards for

protecting Canadians from extremely high prescription drug costs was recommended in both reports.

Standing Senate Committee on Social Affairs, Science, and Technology (Kirby) 2002

The Kirby report (2002) aimed to preserve existing private prescription drug plans and provincial/territorial public prescription drug plans (Kirby & LeBreton, 2002). For the public plans, "personal prescription medication expenses for any family would be capped at 3% of total family income" and then the federal government would pay 90% of prescription drug expenses in excess of $5,000 per year (Kirby & LeBreton, 2002). In an agreement with the sponsors, private plans out-of-pocket costs would be controlled by limiting the costs to $1,500 or 3 percent of family incomes (Kirby & LeBreton, 2002). The lesser value in this respect would be the amount covered by the federal government (Adams & Smith, 2017). The government would then pay 90 percent of prescription drug costs in excess of $5,000 per year (Kirby & LeBreton, 2002). Any difference between out-of-pocket costs and $5,000 would be the responsibility of both the public and private plans (Adams & Smith, 2017). Furthermore, private plans would be encouraged to pool their risk (Adams & Smith, 2017). On the whole, the cost of the Kirby (2002) Pharmacare proposal was estimated at $500 million per year (Kirby & LeBreton, 2002).

Royal Commission on the Future of Health Care in Canada (Romanow) 2002

The Romanow Commission aimed to build consensus through incremental Pharmacare reform (Forest, 2004). The commission recommended a $1 billion catastrophic drug transfer from the federal government to provinces and territories (Romanow, 2002). Through this transfer, the federal government would reimburse 50 percent of the expenses sustained by provincial and territorial prescription drug plans above a threshold of $1,500 per person per year. Furthermore, five mechanisms to elevate equity, enhance access to new medicines, as well as,

expand coverage of prescription medicines in Canada was included in the final report (Armstrong et al., 2003). Armstrong et al (2003) describe these five mechanisms (p.42):

1. The establishment of a National Drug Agency to evaluate new and existing medications for safety, efficacy, and cost.
2. The development of a national formulary for prescription for prescription drugs to provide consistent coverage across the country.
3. A thorough review of Canada's patent protection for pharmaceuticals with a view to improving access to cheaper generic medicines.
4. The adoption of a medications management program linked to primary health care which would allow for monitoring of prescription drugs by a team of health care providers working with patients.
5. A substantial increase in federal contributions to provincial and territorial drug plans through a 'Catastrophic Drug Transfer.'

Overall, this was a sufficient strategy by the Romanow Commission to meet its primary goal of increasing prescription drug coverage to all Canadians under the *Canada Health Act*.

Post-Kirby & Romanow. The federal and provincial governments responded to the Kirby and Romanow reports in 2003 and 2004. The response was made in two health accords or intergovernmental agreements on health policy (Boothe, 2013). In 2003, the First Ministers decided by March 2006 Canadians would have reasonable access to catastrophic drug coverage (CICS, 2003). In 2004, the First Ministers committed to "develop, assess and cost options for catastrophic pharmaceutical coverage," however, majority of the discussions revolved around pharmaceutical management (CICS, 2004). In addition, health ministers were guided by First Ministers to develop a nine-point National Pharmaceutical Strategy (NPS) along with financial figures for catastrophic drug coverage (CICS, 2004). Their progress report was issued in 2006 and recommended additional research on catastrophic drug coverage including four other recommendations on management priorities. (Health Canada, Strategic Policy Branch, 2006). Supplementary reports were not issued on these matters and recommendations originating from the Kirby and Romanow report were not adopted (Boothe, 2013).

House of Commons Standing Committee on Health Report 2018

Based on my review so far, the effect of recommending an incremental strategy for nationwide Pharmacare at the federal level has been small. Flood et al (2018) explain, "despite some provincial initiatives, Canada has been unsuccessful in ensuring nationwide access to even a basic set of prescription drugs" (p.7). In April 2018, the report entitled *Pharmacare Now: Prescription Medicine Coverage for All Canadians* by the House of Commons Standing Committee on Health (HCSCH) concluded it was "time to move forward and create a universal single public payer prescription drug coverage program for all Canadians" (p.83). Expanding the CHA to include "prescription drugs dispensed outside of hospitals as an insured service" was recommended as the best approach for creating the program (HCSCH, 2018, p.83). The reasoning behind this approach was (a) Canada is a federated state and (b) program delivery should occur collaboratively by federal, provincial and territorial governments (HCSCH, 2018). In terms of a drug coverage program, the committee recommended (HCSCH, 2018, p.84-84):

1. Cost-sharing between federal, provincial, and territorial governments.
2. Development of a national voluntary prescription drug formulary with collaboration between the three governments, health care providers, patients, and Indigenous communities to help guide reimbursement decisions and promote consistency in drug coverage listing decisions across the country.
3. To not use co-payments as a means of financing the program to ensure Canadians do not face financial barriers in accessing medically necessary prescription drugs.
4. Expand and build capacity within the Canadian Agency for Drugs and Technology (CADTH) and pan-Canadian Pharmaceutical Alliance (pCPA) to support the development of a pan-Canadian formulary and more robust price negotiations.
5. Governments provide the tools and supports to health care providers who prescribe medicines to do their job effectively and ensure the medicines prescribed are appropriate and do not result in adverse health outcomes.

Advisory Council on the Implementation of National Pharmacare 2018

In the same year, the Minister of Finance announced in the 2018-2019 budget presented to the House of Commons in February 2018, the creation of an Advisory Council on the

Implementation of National Pharmacare (Grignon et al., 2020). This Advisory Council was chaired by Dr. Eric Hoskins, Ontario's former Minister of Health and Long-Term Care. The council officially began to fulfill its mandate on June 20th, 2018 (Grignon et al., 2020). The council was made up of six additional members: a patient representative, a health care provider, a health policy expert, economic policy expert, and two former provincial politicians. Consultations were done with a wide range of stakeholders that included: Canadians, provincial and territorial governments, Indigenous peoples, experts, patient groups, insurers, and pharmaceutical companies (Government of Canada, 2019). The council was asked to prepare a plan that would be accepted by the majority of stakeholders. In addition, the council was directed to consider three options for national Pharmacare (Grignon et al., 2019, p.8):

1. A universal public plan for all Canadians;
2. A public catastrophic insurance plan that would kick in once spending on prescription drugs reaches a given threshold;
3. Patching of existing gaps by providing coverage to those who are not eligible for any form of coverage (with a minimum basket of coverage).

Last, the final proposal prepared by the council needed to be fiscally responsible and not increase taxes (Grignon et al., 2020). The council released its final report entitled *A prescription for Canada: Achieving Pharamcare for All* (Hoskins Report) in June 2019 and included a plan and strategy for nationwide Pharmacare (Government of Canada, 2019).

Liberal Party of Canada (LPC)

The majority Liberal government was nearing the end of its 4-year mandate when it announced the creation of an Advisory Council on the Implementation of National Pharmacare in February 2018 (Grignon et al., 2019). The Liberals won a majority in the 2015 federal election on a platform that championed the Canadian state as a main actor in social matters (LPC, 2015). The focus of the previous nine-year Conservative government was the containment of public

spending and the expansion of public programs was not considered a priority (Morgan & Boothe, 2016). Grignon et al (2019) describe, the Liberals "needed a social accomplishment to fend off opposition from other parties" in the next federal election scheduled for October 2019 (p.6). With the release of the Hoskins Report in June 2019 the LPC aimed to: (a) deter the opposition from the left-of-centre New Democratic Party Canada (NDP) (b) make Pharmacare a core theme of their 2019 federal election campaign and (c) possibly expropriate a long-standing plank of the NDP platform (Canadian Press, 2018; Grignon et al., 2019). Progressives have consistently called for nationwide Pharmacare and the NDP platform includes an explicit plan for national, single-payer Pharmacare (NDP, 2019). The NDP intends to expand the definition of insured services under Medicare to include a well-defined formulary of prescription drugs for usage outside of hospitals (NDP, 2019; Grignon et al., 2019). Taken as a whole, the creation of the Advisory Council by a majority Liberal government, plus the release date of the Hoskins Report, was valuable to the LPC's federal election campaign in 2019.

Hoskins Report 2019

The Hoskins Report makes sixty recommendations on how to achieve nationwide Pharmacare in Canada. It explicitly calls for the implementation of single-payer payer universal Pharmacare. More importantly, the report puts nationwide Pharmacare *once again on the table federally* and contrasts the appeals in the Kirby and Romanow reports for catastrophic drug coverage. The Advisory Council on the Implementation of National Pharmacare studied a range of models that could offer guidance in developing a national Pharmacare program in Canada (Government of Canada, 2019). These models were derived from within Canada as well as internationally. It was "observed that countries with a high performing health system include prescription drug coverage as part of their publicly funded universal health plan" (Government

of Canada, 2019, p.10). This type of health system design increases the bargaining power with pharmaceutical companies and lowers drug prices (Government of Canada, 2019). On this basis, the report emphasizes prescription drug coverage should be organized universally and is the best plan for Canada.

The recommendations made in the report are distributed among twelve different areas (2019): principles of national Pharmacare; government collaboration; indigenous engagement; creating a Canadian drug agency; developing a national formulary; national strategy on appropriate prescribing and use of drugs; national strategy for expensive drugs for rare diseases; financing national Pharmacare; legislation; transition support; information technology and drug data; supporting federal measures. Lewis (2020) describes the report as "clear and principled, and acting on all or most of what it prescribes would make things better" (p.2). In addition, the report presents the failings of the Canadian drug sector. For example, $34 billion was spent on prescription drugs in 2018 and drugs made up the second largest expenditure in health care (Government of Canada, 2019). Comparatively, only the United States and Switzerland pay more for prescription drugs per capita (Government of Canada, 2019). Despite the high spending on drugs in Canada, the council found significant gaps in prescription drug coverage and access. This situation is described as 'unfair' to Canadians. It has created poor outcomes as well as drug costs that are unsustainable and uncontrollable (Government of Canada, 2019). The report details (2019), "one in five Canadians struggle to pay for their prescription drug coverage; three million don't refill their prescriptions because they can't afford to; and one million Canadians cut spending on food and heat to be able to afford their medicine" (p.7). Overall, the report deems the status quo unacceptable and highlights prescription drugs are a crucial commodity for achieving and maintaining health in Canadian society.

Legislation & Canadian Drug Agency

The Hoskins Report recommends national Pharmacare should be enacted by new federal legislation. In particular, this legislation would integrate the fundamental principles of the CHA (Government of Canada, 2019, p.11):

1. Universal: all residents of Canada should have equal access to a national Pharmacare system;
2. Comprehensive: Pharmacare should provide a range of safe, effective, evidence-based treatments;
3. Accessible: access to prescription drugs should be based on medical need, not ability to pay;
4. Portable: Pharmacare benefits should be portable across provinces and territories when people travel or move; and
5. Public: a national Pharmacare system should be both publicly funded and administered.

Also, the report recommends the implementation of Pharmacare should occur on a step-by-step basis in collaboration with provinces and territories (Government of Canada, 2019). This process would begin with the creation of a Canadian Drug Agency which will first be tasked with creating a national formulary.

National Formulary & Copayments

A national formulary is a list of drugs covered by national Pharmacare. The initial list would be a carefully selected list of essential medicines (Government of Canada, 2019). Essential medicines cover half of all prescriptions in Canada and the list will become available January 1st, 2022 (Government of Canada, 2019). The report recommends a copayment of $2 for drugs on the EML and $5 for drugs excluded from the list (Government of Canada, 2019). The report states copayments will take place within strict limits: copayments will be capped at $100 for each person or household per year; social assistance, government disability benefit, or federal Guaranteed Income Supplement benefit recipients will be exempt (Government of Canada, 2019). Lastly, the council studied Canadians with rare diseases who rely on new expensive drugs

to improve their health and recommends the development of a national strategy for expensive drugs with rare diseases (Government of Canada, 2019).

Federal Leadership & Funding

To launch national Pharmacare the council has estimated it will cost an additional $3.5 billion in 2022 beginning with the universal coverage of essential medicines (Government of Canada, 2019). A comprehensive national formulary is expected to be in place by January 1st, 2027 (Government of Canada, 2019). An annual incremental cost to cover the comprehensive list of drugs is estimated to reach $15.3 billion in 2027 (Government of Canada, 2019). The report states the federal government should pay for the implementation of a national Pharmacare program (Government of Canada, 2019). The council recognizes this investment will have major fiscal implications but the issues with drug coverage in Canada are too critical to ignore (Government of Canada, 2019). They have proposed the creation of a new fiscal transfer to support the Pharmacare program (Government of Canada, 2019). Specifically, the council explains a new fiscal transfer should be "long-term, predictable, fair and acceptable to provinces and territories" (Government of Canada, 2019, p.14). Overall, the Hoskins Report emphasizes the role of strong federal leadership and funding for the implementation of a nationwide Pharmacare program in Canada.

Conclusion

I reviewed several periodic proposals for nationwide Pharmacare at the federal level spanning over eighty years. The original proposal for public health insurance considered in the late 1940s, established medicines were a public good, and should be a part of a public health insurance system. To date, the federal government has *not* incorporated prescription drugs used outside of hospitals into the Canadian public health insurance scheme. The 2019 Hoskins Report

verifies prescription drugs are (a) commonly used to improve and maintain the health of Canadians and (b) important for delivering healthcare within the Canadian public health system equitably.

The recommendations made in the Hoskins Report are required to address the shortcomings of the current prescription drug coverage regimes operating in Canada. Segments of the Canadian population have difficulty accessing this public health good. Drug coverage in Canada is not aligned with the fundamentals of the Canadian health system which are: access to healthcare should be based entirely on need and that all members of society share the cost of care (Morgan & Daw, 2012). The Hoskins Report appears on behalf of the LPC and indicates that a nationwide universal Pharmacare program is once again on the table federally. Based on this key message, I posit the question: What messages can be found to inform the path forward regarding the LPC's proposal for a nationwide universal program of pharmaceutical insurance or 'Pharmacare' by comparing the Canadian approach to prescription drug coverage with that of the United Kingdom (UK)?

Methodology

I selected a qualitative approach for this study. The underlying philosophy of qualitative research is constructionism (Merriam, 2009). Constructionism observes how the interactions of individuals with their social world constructs reality (Merriam, 2009). Each phenomenon is understood based on the meaning it has for those involved (Merriam, 2009). Meaning is not discovered but constructed by human beings when they engage with the world they are interpreting (Crotty, 1998).

Critical Research and Political Economy Framework

Among the different types of qualitative research, I have selected the critical style for this study. “In critical inquiry the goal is to critique and challenge, to transform and empower” (Merriam, 2009). It goes beyond studying and understanding “society, but rather to critique and change society” (Patton, 2002). In particular, I make use of the political economy framework found within critical research. It focuses on “how the political and economic systems lead to the unequal distribution of influence, power, and health” (Bryant, Raphael, and Rioux, 2010, p.134). The application of this framework to my inquiry brings attention to the political and economic structures of society and relates closely to the issue I am examining.

Bryant, Raphael, and Rioux, (2010) explain, “political economists focus on the c*ontrol of material resources and production* through analysis of economic structures concerned with finance and commerce and *control of human resources and people* through analysis of political structures of the state” (p.134). In essence, there are two overarching institutions that shape most modern societies: capitalism (the market economy) and democracy. The capitalist mode of production represents the way society is formed today (Coburn, 2010). In a capitalist social formation, capitalism influences everything from “the beliefs people have, to what they consider desirable, to prevalent ideas, to politics, to social life, either very directly or indirectly” (Coburn, 2010, p.67). Fundamentally, capitalism is able to shape and limit what is possible (Coburn, 2010). It makes the assumption that almost all people have an equal opportunity to influence events (Coburn, 2010). In contrast, democracy ensures that some people may have a respectable chance to influence events (Coburn, 2010). These two institutions are not intrinsically compatible and routinely need to be reconciled. In a liberal democratic capitalist state, such as Canada and the United Kingdom, policymaking is a constant juggling of private and public

interests. Ideally, society and state should be strong in which they can form a cooperative relationship.

Realism as a Knowledge Paradigm

Political economy as a theory belongs to the knowledge paradigm 'realism' in health system studies. Realism allows the researcher to identify and analyze social structures through which they can establish how societal economic, social and political resources are allocated (Bryant, Raphael, & Rioux, 2010). It concerns itself with what people understand about societal structures and how these structures create the distribution of resources (Bryant, Raphael, & Rioux, 2010). Bryant, Raphael, & Rioux (2010) explain, "realism's primary thesis is that analysis of health, illness, and health care must not be limited to the concrete and observable…instead strive to identify how economic and political structures interact with the existence of different classes, status groups, and associations in society to create differences in health and illness" (p.124). Overall, the realist toolkit allows me to critically analyze the health systems my study has selected for comparison and inform the research problem.

Methods

My review of the periodic proposals for nationwide Pharmacare in Canada at the federal level produced a key message: the release of the 2019 Hoskins Report on behalf of the LPC, indicates that a nationwide universal Pharmacare program is once again on the table federally. The Hoskins Report detailed the universal comprehensive health coverage that has been underway in the UK since the National Health Service (NHS) was created in 1948, and prompted the question (Tikkanen et al., 2020): What can we learn from the UK experience? To answer this question, I utilize the comparative approach. I compare the Canadian approach to prescription drug coverage with that of the United Kingdom (UK). Specifically, I compare Canada and the

UK in three clusters: (a) the levels and sources of expenditures on prescription drugs; (b) the levels and distribution of pharmaceutical insurance associated with prescription drug spending; and (c) the health outcomes "produced." Based on this comparison, I present any messages that inform the path forward on the LPC's proposal for nationwide Pharmacare.

I selected the UK as a comparator country because it shares key country characteristics with Canada: (a) English-speaking; (b) liberal welfare regime; and (c) member of the OECD with a universal public health system. According to the OECD health spending indicator, in 2018 Canada and the UK spent a similar percent of their total gross domestic product (GDP) on health care. The UK spent 9.8 percent and Canada spent 10.7 percent respectively. Among the OECD countries with universal health insurance, Canada is the only country that does not provide coverage of prescription pharmaceuticals (Flood et al., 2018). The UK's public health insurance scheme covers the cost of prescription drugs for their citizens without deductibles and with limited or no copayments for eligible prescription drugs (Government of Canada, 2019). Intriguingly, the health system in the UK covers the cost of prescription drugs for their citizens while spending less of their total GDP on health care than Canada. I will provide more details about the UK health system in subsequent sections.

Data Collection

This study is based on a review of peer-reviewed and grey literature. The data is collected through searches on the Google Scholar website using combinations of the terms: 'Pharmacare,' 'Canada,' 'Canadian,' 'prescription drug,' 'drug coverage,' 'health system,' 'national,' 'provincial,' 'United Kingdom (UK),' 'health outcomes,' 'drug expenditure'. Published books, public reports, policy papers, government webpages, international agency reports and other forms of grey literature were collected from iterative google searches to provide a complete view

of the current state on this topic. There were no date restrictions, though preference was given where possible to newer information sources for this narrative review.

I acknowledge the lack of a reproducible, systematic search strategy may be a significant limitation of my review. However, I maintain that combining the various aspects of the Pharmacare topic (economics, policy, politics, health outcomes and systems) into a coherent work is more amenable to a realist, narrative strategy than a rigorous systematic approach.

Data Analysis

The overarching goal of this study is to inform the path forward on a major federal health care policy proposal (nationwide Pharmacare) in Canada via international comparison. My study does not constitute a formal comparative analysis. However, I carefully consider for each country: the levels and sources of expenditures on prescription drugs; the levels and the distribution of pharmaceutical insurance associated with these expenditures; as well as the health outcomes produced in an international context. The data for analysis in this study is context-sensitive and the evaluation of the literature is directed by the political economy framework. I interpret the literature by placing the information in a political-economic context. This approach allows me to gather evidence on the role each nation-state plays for the coverage of prescription drugs to their citizens. Additionally, the framework gives me the capacity to reveal the health-related outcomes for each country. Overall, the political economy framework is reliable for informing the path forward on a major public health care policy proposal. The next section provides more detail on the political economy framework within qualitative research.

Canadian Approach to Prescription Drug Coverage

In Canada, prescription drug coverage is uncoordinated and complex (Brandt et al., 2018). Drugs prescribed outside of the hospital setting (outpatient prescription drugs) are excluded from the

core benefits under Canadian Medicare (Schoen et al., 2010). The lack of a national standard for prescription drug coverage has produced a system often referred to as a patchwork.

Coverage

Prescription drugs are covered through a mix of public and private insurance plans, as well as out-of-pocket payments (Daw & Morgan, 2012. Typically, payments are made by a resident for the following reasons (Kratzer et al., 2013; as cited in Law et al., 2018):

- if they do not have drug coverage;
- for drugs not covered by an insurance plan;
- to satisfy the deductible requirements of public or private insurance coverage; and to pay the out-of-pocket prescription charges common to most public and private drug plans.

In terms of public and private drug plans, there are different requirements for eligibility, patient charges, and drugs covered (ex. formularies) (Daw & Morgan, 2012). Co-payments, co-insurance, and/or deductibles are common to both and all reflect a cost to the resident (OPBO, 2017). The Office of the Parliamentary Budget Officer (OPBO) (2017) reports, deductibles are rare for private insurance plans. Sixty-seven percent of beneficiaries of a private drug plan pay co-insurance and 17% make fixed co-payments (OPBO, 2017). I provide more detail on the different types of coverage for prescriptions drugs found in the Canadian health system in the following sections.

Provinces & Public Drug Programs

Provincial governments cover the cost of prescription drugs via public drug programs for vulnerable populations such as: the very poor, the elderly, and people facing catastrophic costs (Flood, 2018). “Access to public funding for essential medicines (medicines that meet the priority health care needs of a population [WHO, 2020]) is a lottery, based on a residents age, income, medical condition and province of residence” (Flood, 2018, p.9). The public drug plans

offered by provinces are considerably different in terms of *who* is covered (Brandt et al., 2018). Particularly, Manitoba and British Columbia no longer provide comprehensive coverage for seniors (Brandt et al., 2018). Public drug programs began to evolve in the 1960s and 1970s, with comprehensive public drug insurance originally offered to residents over the age of 65, and residents on social assistance (Grootendorst, 2002).

Catastrophic Drug Programs

Public drug programs for residents facing catastrophic costs have the most variation across provinces (CIHI, 2018). The purpose of a catastrophic drug program offered to the general population (non-senior and non-social assistance) is to safeguard residents with medication expenses that result in undue financial hardship (CPA, 2017). This type of program is usually 'geared-to-income' and the beneficiary pays for the cost of the drugs until the predetermined maximum has been reached (CPA, 2017). The maximum is calculated based on the income of the beneficiary (CPA, 2017). Notably, universal comprehensive public drug coverage is not provided by any province (CIHI, 2018).

Private Insurance

Those who are unable to access public funding for prescription drugs either pay out-of-pocket or have private insurance arrangements. Similar to public drug plans, private health insurance plans that cover pharmaceuticals include a formulary (OPBO, 2017). Generally, private drug plan formularies are broader in relation to their public counterparts (OPBO, 2017). Private insurance for prescription drugs is voluntary (except in the province of Quebec) and usually provided by employers to employees to satisfy compensation packages (Brandt et al., 2018). Specifically, the employee must qualify for extended health benefits with their employer

(Brandt et al., 2018). Last, compensation packages for employees are usually negotiated between employers and unions (Brandt et al., 2018).

The Canadian Pharmacists Association (CPA) estimates, to help cover the cost of prescription drugs, 24 million Canadians have supplementary private health insurance (2017). In a report by the Wellesley Institute, (non-profit charity that works in research and policy to improve health and health equity) it was estimated two-thirds of working-Canadians have private insurance coverage (Barnes & Anderson, 2015). Specifically, full-time employees, over the age of 25, and earning over $30,000 are more likely to have access to private insurance coverage than part-time employees, low-wage earners, and those under the age of 25 (Barnes & Anderson, 2015). As cited in Brandt et al (2018), in a 2016 survey by Law et al (2018), 59% of Canadians reported possessing some form of private insurance. On the whole, full-time working Canadians are most likely to have access to private insurance for prescription drugs prescribed outside of the hospital setting.

The Patchwork System

The information presented above on the different kinds of prescription drug coverage reflects a patchwork system for prescription drug coverage in Canada. Residents obtain coverage through public or private drug plans or out-of-pocket payments. One in five Canadians report they do not have coverage for their prescription drugs (Law et al., 2018). Out-of-pocket costs have resulted in Canadian residents not filling the prescriptions written for them (Brandt et al., 2018). This important fact is derived from several surveys conducted over 15 years (Brandt et al., 2018). I highlight these studies below.

Studies on Cost-Related Nonadherence

Kennedy and Morgan (2006) studied the rate of cost-associated nonadherence in Canada and the United States. For both countries their study identified factors that predicted cost-associated nonadherence. The study reported residents with inadequate insurance, young age, poor health, chronic pain and low household income were likely to report 'failing to fill a prescription due to cost'. In 2009, Kennedy and Morgan designed a study which compared the rate of cost-related nonadherence (CRNA) (being unable to fill prescription due to cost) in Canada and the United States across core financing methods. In particular, the study found 4.4% of working-age adults reported CRNA in Quebec where prescription insurance is compulsory for residents.

In 2012, a study published in the Canadian Medical Association Journal (CMAJ) by Law et al (2012) used data from the 2007 Canada Community Health Survey and analyzed the responses for 5732 people who answered questions regarding CRNA to treatment. Their study reported CRNA for 1 in 10 Canadians who received a prescription. The study concluded a main factor of this phenomenon was the variation in insurance coverage for prescription drugs. Later in 2017, Morgan and Lee reported Canada had the second highest prevalence of CRNA in their assessment of effects of costs on access to medicines in 11 developed countries which offer the public various forms of prescription drug coverage. In relation to the UK, Morgan and Lee (2017) found older adults in Canada were 'statistically significantly more likely' to report CRNA. Also, the prevalence of CRNA was higher among lower income residents across most countries (Morgan & Lee, 2017). For residents over the age of 65 the prevalence of CRNA was lower (Morgan & Lee, 2017).

Law et al (2018) devised and fielded cross-sectional questions to 28,091 Canadians, as part of the 2016 Canadian Community Health Survey, concerning (a) prescription drug affordability (b) consequent use of health care services and (c) trade-offs with other expenditures. To establish which patient characteristics were connected to those behaviours, Law et al (2018) used logistic regression and made calculations for weighted population estimates and proportions. The study concluded cutting out prescription drugs, other necessities, and additional health care services, was linked to out-of-pocket payments for medications among Canadians. To avoid these negative outcomes, changes need to be made to safeguard vulnerable population from the cost of prescription drugs (Law et al., 2018).

In 2018, the Canadian Federation of Nurses Unions (CFNU) published a report which estimated hundreds of early deaths in Canada due to the difficult experience residents have in paying for prescription drugs (Lopert et al., 2018). A range of sources were used for an estimate of "premature loss of life due to CRNA to prescription medicines in Canada" (Lopert et al., 2018, p.21). Lopert el al (2018) explain, if these premature deaths had access to universal, comprehensive prescription drug coverage, the deaths could be avoided. Also, thousands of residents suffer with the degradation of health when coverage of prescription drugs is inadequate (Lopert et al., 2018). The patchwork system of public and private drug plans is unfair, inefficient, expensive and fragmented (Lopert et al., 2018). Around $7.3 billion a year is wasted in health care dollars because of this system (Lopert et al., 2018). To conclude, 1 in 5 Canadians is falling through the cracks (Lopert et al., 2018).

Conclusion

The Canadian approach to prescription drug coverage is evidently not organized at the federal level. Canadian residents across all populations and life stages do not similarly access

their coverage for prescription drugs prescribed outside of the hospital setting. Coverage could be in the form of out-of-pocket payments, public drug programs, or private health insurance. Medicines covered under these kinds of coverage varies. Usually, public drug programs exist for the most vulnerable groups or to cover catastrophic drug costs. Private health insurance is provided by employers to employees in the form of workplace benefits. Those paying for medicines out-of-pocket can only obtain medicines that fall within their budget. Also, a resident who pays out-of-pocket for their medicines may select to forgo their prescription entirely. Many studies have been completed on the presence of CRNA in Canada. Taken as a whole, this system for prescription drug coverage outside of the hospital setting is not comprehensive or universal. Access to coverage may be restricted to a resident for a number of reasons. Therefore, the Canadian approach to prescription drug coverage can be deemed inequitable.

United Kingdom's Approach to Prescription Drug Coverage

The UK is a high-income country with a universal health care system that provides universal coverage for prescription drugs (Morgan, 2018a). Universal comprehensive health coverage has been underway in the UK since the National Health Service (NHS) was created in 1948 (Tikkanen et al., 2020). The intent of the NHS was to provide access to health care for all residents, regardless of their ability to contribute to its financing (Boyle, 2011). Boothe (2012) states, in terms of welfare state development, the "NHS was a groundbreaking achievement." The policies for drug coverage, pricing, and financing have been effectively developed (Morgan, 2018a). Importantly, these policies are operational within the broader context of the universal health care system in the UK (Morgan, 2018a).

Universal coverage of prescription drugs is provided for people of all ages and incomes (Morgan, 2018a). The population-based financing system for health care in the UK also finances

the Pharmacare system (Morgan, 2018a). In a report prepared for the Advisory Council on the Implementation of National Pharmacare in Canada, Dr. Steve Morgan (2018a) states, "this combination of true universality and health system integration…allows a country with universal Pharmacare to strike a balance between sometimes-competing pharmaceutical policy objectives, such as encouraging the use of necessary medicines while controlling costs" (p.5). On the whole, prescription drug coverage is an integral component of the national health insurance system in the UK (Morgan, 2018a).

National Health Service (NHS)

The NHS was set up under the National Health Service Act of 1946 (Tikkanen et al., 2020). A report with recommendations was provided by Sir William Beveridge in 1942 to parliament and formed the basis of the act. It explained wider welfare reform could be achieved through free health care and reduce unemployment, poverty, and illness, as well as raise education levels among the population (Tikkanen et al., 2020). The 1946 Act required the Minister of Health to provide a free and comprehensive health service to residents and replace voluntary health insurance and out-of-pocket payments (National Health Service Act, 1946). Today, the NHS is largely free at the point of use to all residents (Boyle, 2011). Finally, it continues to adhere to its goals established at its inception in 1948.

Universal Coverage, Governance, & Health Services

The National Health Service (NHS) in the UK provides universal coverage for a comprehensive range of health services (Boothe, 2012). Accordingly, coverage for prescription drugs outside and inside hospital setting(s) is universal (Morgan, 2018a). The Pharmacare system in the UK is organized and financed through a universal, single-payer, public system (Morgan, 2018a). Morgan (2018a) explains, prescription drugs in the UK are financed through a variety of

sources for government revenue. Sometimes government revenue from taxes are earmarked for health care, including pharmaceuticals (Morgan, 2018a).

Services include preventative medicine, primary care, and hospital services for all individuals "ordinarily resident" (Boyle, 2011). 'Ordinarily resident' refers to individuals in the UK who are not residing temporarily or illegally (Cylus et al., 2015). Individuals who are ordinarily resident can access healthcare anywhere in the UK (Cylus et al., 2015). Voluntary supplemental insurance to acquire fast access to elective care is possessed by approximately 10.5 percent of the UK population (Tikkanen et al., 2020).

Governance

Parliament, the Secretary of State for Health, and the Department of Health hold the responsibility for health legislation and general policy (Tikkanen et al., 2020). Each country in the UK has its own NHS that oversees healthcare: NHS England, NSH Scotland, NSH Wales, and Health and Social Care in Northern Ireland (Tikkanen et al., 2020). These are arm's-length government bodies and operate separately from the Department of Health (Tikkanen et al., 2020). Tikkanen et al (2020) highlight their responsibilities which include:

- Managing the budget;
- Overseeing local Clinical Commissioning Groups (CCGs), which are groups of local general practitioners (GPs) who plan, commission, and pay for most of the hospital and community service in their areas;
- Directly commissioning certain types of care, including primary care in some areas, dental care, treatments for rare conditions, and some public health services;
- Working toward objectives in the annual mandate from the Secretary of State for Health, which include both efficiency and health goals;
- And setting the strategic direction of health information technology, including the development of online services to book appointments and the setting of quality standards for electronic medical record-keeping and prescribing.

Hospitals and providers of NHS care (ambulance services, mental health services, district nursing, other community services) are owned by the government (Tikkanen et al., 2020). Lastly, these providers are referred to as NHS trusts (Tikkanen et al., 2020).

Health Services Covered

A specific list of health services covered by the NHS does not exist (Cylus et al., 2015). Legislation developed in the 1970s orders ministers to ensure necessary health services are delivered to the public (Cylus et al., 2015). More specifically, the National Health Service Act of 1977 places responsibility on the Secretary of State for Health to provide health services "to such extent as she considers necessary to meet all reasonable requirements" (Boyle, 2011, p.80). NHS care is free at the point of use and the NHS Constitution of England outlines the rights for those eligible for care (Tikkanen et al., 2020; Boothe, 2012; DHSC, 2015).

Drugs and Treatments. Under the heading 'nationally approved treatments, drugs and programmes' it states patients are entitled to (DHSC, 2015):

1. The right to drugs and treatments that have been recommended by the National Institute for Health and Clinical Excellence (NICE) for use in the NHS, if your doctor says they are clinically appropriate for you.
   The right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

Importantly, NICE is responsible for publishing and assessing guidance of new and existing medicines, treatments, as well as procedures within the NHS (Boyle, 2015). NICE was established in 1999 and its role has since been extended to providing guidance on public health (Boyle, 2015). Other areas in which the NHS Constitution outlines the rights of the patient are: (a) access to health services (b) quality of care and environment (c) respect, consent and confidentiality (d) informed choice and (e) involvement in your healthcare and the NHS (DHSC,

2015). Morgan (2018a) notes, when considering the lessons, the United Kingdom provides with regards to universal, comprehensive coverage for medically necessary drugs, their technique of formulary management is key.

National Formulary. Formulary management appears to be nationalized by the NHS (Morgan, 2018a). This was developed through their practice of centralized contracting for the supply of specialty medicines with high costs (Morgan, 2018a). Cylus et al (2015) state, "there is a UK-wide 'Pharmaceutical Price Regulation Scheme' (PPRS) controlling the pricing of non-generic drugs purchased by the NHS throughout the UK, with profit limits for companies and an overall cap on expenditure." The goal of this scheme is to help the NHS purchase medicines at fair prices alongside the promotion of a strong pharmaceutical industry (Cylus et al., 2015). This scheme does not apply to generic medicines (Cylus et al., 2015). Additionally, price-regulation does not occur for over-the-counter (OTC) medicines. Finally, this scheme, including the specific rights of patients found within NHS constitution, function as patient empowerment strategies for the public health insurance system (Cylus et al., 2015).

Pharmacists, Pharmacy Technicians & Pharmacy Premises. In the UK all pharmacists, pharmacy technicians and pharmacy premises must register with the General Pharmaceutical Council (GPhC) (Cylus et al., 2015). Registration for these entities must be renewed annually (Cylus et al., 2015). Also, inspection for pharmacy premises occur every five years. Local bodies in Scotland, Wales, and Northern Ireland conduct the inspections for pharmacy premises (Cylus et al., 2015). A third of the pharmacists in the UK are hospital pharmacists (Boyle, 2011). They are salaried employees under the 'Agenda for Change' pay system (Boyle, 2011). The remaining pharmacists are community based (Cylus et al., 2015). Those pharmacists are paid from: (i) profits retained at their respective pharmacies (ii) the global sum and (iii) budgets of their

commissioning body (Cylus et al., 2015). Also, the pharmacy receives a dispensing fee per item (Cylus et al., 2015). The commissioning body of the pharmacy provides practice payments (Cylus et al., 2015). The practice payments are linked to the amount of dispensed prescriptions at the fixed fee inside a pay band (Cylus et al., 2015).

Conclusion

The approach to prescription drug coverage in the UK is a universal, single-payer, public system. Residents of the UK, across all populations, and life stages, similarly access their coverage for prescription drugs prescribed outside of the hospital setting. Prescription drugs fall under the comprehensive range of health services provided by the NHS. National health legislation was established early on and ensures necessary health services are delivered to the public. Thus, the policies for drug coverage, pricing and financing have been effectively developed (Morgan, 2018a).

The NHS Constitution of England outlines the rights of residents involving 'nationally approved treatments, drugs, and programs' (DHSC, 2015). These rights address the drugs and treatments recommended by NICE for use in the NHS, as well as, local decisions for funding other drugs and treatments. A list of medically necessary drugs or formulary is managed at the national level. The Pharmacare system in the UK applies a price regulation scheme to control the price of non-generic drugs (Cylus et al., 2015). This scheme is applicable across the UK, endorses profit limits for pharmaceutical companies, including an overall cap on expenditure for drugs purchased by the NHS (Cylus et al., 2015). Through these multiple strategies, the public health insurance system can purchase non-generic (branded) medicines at fair prices, promote a strong pharmaceutical industry, and empower its patients.

It is important to note, copayments exist in England and patients pay $15.00 (£8.80) for each item dispensed at a pharmacy (Government of Canada, 2019). Patients in England have the option to make a prepayment of $50.00 (£29.10) for 3 months or $176.00 (£104) for 12 months (Government of Canada, 2019). Copayments are not required by patients in Scotland, Wales or Northern Ireland (Government of Canada, 2019). Although copayments in England are not excessive or high, there is strong evidence that it can create barriers to access (Government of Canada, 2019). People may skip their medication or take them inappropriately due to copayments (Government of Canada, 2019). Those with complex or chronic health problems and low incomes can find it difficult to make copayments (Government of Canada, 2019). Nonetheless, copayments are considered a standard practice for prescription drug insurance and comparable countries with universal prescription drug coverage require a minor copayment on prescription drugs (Government of Canada, 2019).

Last, the approach to prescription drug coverage in the UK is directly linked to its broader public health system. Health services in the UK are provided by the NHS and Boothe (2012) has described it as a "significant innovation in terms of population covered, the range of health services included, and the mechanism for coverage" (p.788). Scholarly literature by Hacker (1998), Tuohy (1999) and Klein (1995) explain why the UK introduced this radical health policy 1946 (as cited in Boothe, 2012). A series of public health services were adopted simultaneously for the introduction of a broad public health system in the UK (Boothe, 2012). Outstandingly, the early adoption of a series of public health services has given way to a prescription drug approach that is well developed and aims to balance public and private interests around pharmaceuticals.

Comparing Performance Among Countries

This section compares Canada and the UK in three clusters: (a) the levels and sources of expenditures on prescription drugs; (b) the levels and distribution of pharmaceutical insurance associated with prescription drug spending; and (c) the health outcomes "produced." Canada and the UK both belong to the Organization for Economic Co-operation and Development (OECD). The OECD (n.d.a) is an international organization that operates to establish evidence-based international standards, as well as locate solutions to a range of social, economic and environmental challenges. The OECD has a total of 37 Member countries from North and South America, Europe and Asia-Pacific (n.d.b). Particularly, eighty percent of the trade and investment in the world is represented among the OECD countries and their partners (n.d.b). Belloni et al (2016) explain a significant portion of the overall health care spending across OECD countries is made up of pharmaceuticals. Across OECD countries in 2015 the total **retail pharmaceutical** (see Appendix A for definition) bill was more than USD 800 billion (OECD, 2017). Also, one-fifth of all healthcare expenditure was made up of retail pharmaceuticals in 2017 (OECD, 2019).

Table 1 **Per capita expenditures on retail pharmaceuticals in 2 countries, 2015 & 2017, in US dollars[ab]**

	2015		2017	
	Per capita spending ($)	**% public funding**	**Per capita spending ($)**	**% public funding**
Canada	756	36	806	36
United Kingdom	497	67	469	66
OECD Average	553	57	564	58

Source: OECD Health at a Glance 2017 & 2019.

[a]Conversion using purchasing power parity rates, i.e. rates that reflect the country-specific cost of buying a standard "basket of goods."

[b]Retail pharmaceuticals are provided outside hospital care such as through a pharmacy or bought from a supermarket.

Table 1 presents OECD data on levels of per capita spending on retail pharmaceuticals in Canada and UK for the period 2015-2017 (OECD, 2017; OECD, 2019). Expenditures in Canada remained relatively high during this period, and when compared to UK and OECD average. Also, during this period expenditure in Canada respectively increased; UK expenditures remained stable and decreased slightly; OECD average remained stable and increased slightly. In 2015, the proportion of expenditures contributed from public funds was lowest in Canada than UK, including the OECD average. Further, the proportion of expenditures contributed from public funds was almost double that of Canada in UK during this period. The UK expenditure per capita was substantially lower than Canada. Finally, the public contribution to prescription drug expenditures has remained steady in both these countries between 2015 and 2017.

***Table 2 Per* capita health and pharmaceutical spending in 2 countries, 2015 & 2017, in US dollars[a]**

	2015		2017	
	Canada	**United Kingdom**	**Canada**	**United Kingdom**
Per capita health spending ($)	4610	3828	5155	4126
Per capita pharmaceutical spending ($)	772	481	852	516
Pharmaceutical spending total as % of health spending	16.7	12.6	16.5	12.5
Per capita health spending government schemes ($)	3272	3044	3613	3247

Source: OECD (2020) Health and Pharmaceutical spending indicator.

[a]Conversion using purchasing power parity rates, i.e., rates that reflect the country-specific cost of buying a standard "basket of goods."

Table 2 presents OECD data on levels of per capita health and pharmaceutical spending in Canada and United Kingdom for the period 2015-2017 (OECD, 2020a; OECD, 2020b). **Health spending** (see Appendix B for definition) per capita remained relatively high in Canada during this period and when compared to UK. In Canada and UK health spending per capita respectively increased during this period. Next, **pharmaceutical spending** (see Appendix B for definition) per capita remained significantly high in Canada during this period and when compared to UK. Further, pharmaceutical spending per capita respectively increased in Canada and UK. The pharmaceutical spending total as a portion of health spending remained steady in Canada and UK during this period. Additionally, the Canadian pharmaceutical spending total as a percentage of health spending was respectively higher when compared to UK. Government health care spending per capita respectively increased in Canada and UK during this period. Government health spending per capita in Canada was slightly higher than UK. Last, Canada and UK government health care spending was roughly similar during this period.

At this juncture, it is important to indicate the Canadian approach to prescription drug coverage has resulted in high levels of per capita spending on pharmaceuticals (Table 1 & 2) during the period 2015-2017. The UK approach to prescription drug coverage has resulted in lower levels of per capita spending on pharmaceuticals (Table 1 & 2) when compared to Canada for this period. Interestingly, pharmaceutical spending as a percentage of health spending (Table 2) is higher in Canada compared to UK. In previous sections, I demonstrated that the NHS in the UK provides a comprehensive range of health services to its residents, whereas, Canadian Medicare excludes drugs prescribed outside of the hospital setting (outpatient prescription drugs)

from its set of core health benefits (Schoen et al., 2010). Also, per capita government health care spending (Table 2) is higher in Canada when compared to UK. UK maintained lower levels of pharmaceutical spending as a percentage of health spending (Table 2) and per capita government health care spending (Table 2) during this period.

***Table 3 Cost*-related access problems to medical care in 2 countries, 2015 & 2016**

	% of primary care doctors report their patients often have difficulty paying for medicines or out-of-pocket costs[a]	% of adults who reported they had cost-related access problem to care in the past year[b]
Canada	30	16
United Kingdom	12	7

[a]Source: 2015 Commonwealth Fund International Health Policy Survey of Primary Care Physicians in 10 Nations

[b]Cost-related access problem includes at least one of the following: did not fill a prescription; skipped recommended medical test, treatment, or follow-up; or had a medical problem but did not visit doctor or clinic in the past year because of cost. Source: 2016 Commonwealth Fund International Health Policy Survey.

Table 3 presents data on cost-related access problems to medical care in Canada and the UK (CMWF, 2015; CMWF 2016). The first column shows data on the proportion of primary care doctors who reported that patients often have difficulty paying for medicines or out-of-pocket costs (CMWF, 2015). The second column displays data on the proportion of adults who reported they had cost-related access problems to medical care in the past year (CMWF, 2016). For Canada and UK, the incidence of a primary care doctor reporting the patient had difficulty paying for medicines or out-of-pocket costs was greater than an adult reporting they have had a cost-related access problem to medical care in the past year; this is expected as access to prescription drug coverage is more dependent on user contributions than is medical care in each country.

Cost seems less a barrier in UK than in Canada, about two times as many Canadian primary care doctors reported their patients had difficulty paying for medicines or out-of-pocket costs. Also, 2 times as many Canadians experienced a cost-related access problem to medical care. Since both Canada and UK reported (i) cost as a problem in access to medical care by adults and (ii) patients of primary care doctors often have difficulty paying for medicines or out-of-pocket costs, I want to indicate that both countries' health system is considered 'universal.' The basket of goods covered by the NHS is comprehensive. This is reflected in the lower percentage of (i) adults reporting they had cost-related access problem to care and (ii) primary care doctors reporting their patients have difficulty paying for medicines or out-of-pocket costs. Canadian Medicare does not provide coverage for medicines prescribed outside of the hospital setting (Pharmacare), dental care, long-term care, mental health care and etc. As a result, a higher percentage of Canadian adults reported they had cost-related access problem to care when compared to the UK.

Moreover, a substantially higher percentage of primary care doctors reported their patients often have difficulty paying for medicines or out-of-pocket costs in Canada when compared to the UK. This can be attributed to the fact that out-of-pocket payments are a viable method of prescription drug coverage in Canada. A resident paying for medicines out-of-pocket will only obtain medicines that fall within their budget. Additionally, a resident who pays out-of-pocket for their medicines may select to forgo their prescription entirely.

I demonstrated in an earlier section, many studies have been completed on the presence of CRNA in Canada. The low level of public contribution to the spending on retail pharmaceuticals in Canada impacts the ability of the patient to pay for medicines out of pocket. Usually, the residents impacted belong to less prosperous groups, do not qualify for a provincial drug

program, and cannot access alternative resources (i.e., private insurance or personal resources) that can provide as a substitute for the lack of public contribution. The level of public contribution to the spending on retail pharmaceuticals is greater in the UK and their residents do not have to have to dip into their savings to pay for medicines recommended by NICE for use in the NHS.

Overall, this international lens on the funding and delivery of prescription drug coverage in Canada has generated many points. Canada has high levels of per capita spending on pharmaceuticals (Table 1 & 2). As a result, any perceived problems to prescription drug coverage in Canada are not the result of low levels of spending. Alternatively, the sources of funding and the organization of services must be inspected. The proportion of expenditures on retail pharmaceuticals contributed from public funds was low in Canada compared to the OECD average (Table 1). Pharmaceutical spending as a percentage of health spending was high in Canada (Table 2). Per capita government health spending in Canada was slightly higher than the UK where universal access to prescription drug coverage exists (Table 2).

The consequences of this trend in Canada have been (i) primary care doctors reporting their patients have difficulty paying for medicines or out-of-pocket costs and (ii) adults reporting cost-related access problem to medical care. However, it is a challenge to discover the full consequences of this trend with the absence of systematic data collection on prescription drug coverage levels in the population. Overall, the absence of any universal publicly funded prescription drug coverage program for residents appears to be restricted to North America.

Key Messages

A review of the periodic proposals for nationwide Pharmacare in Canada at the federal level brought forward a key message. The message is that a nationwide Pharmacare program is

once again on the table federally. Prescription drugs used outside of the hospital setting are not covered by the Canadian public health insurance system. The original proposal for public health insurance tabled in the late 1940s established medicines were a public good and should be a component of the system. The 2019 Hoskins Report released by the LPC demonstrates prescription drugs are (a) commonly used to improve and maintain the health of Canadians and (b) important for delivering healthcare within the Canadian public health system equitably. The report makes 60 recommendations on how to achieve nationwide Pharmacare in Canada and openly calls for the implementation of single-payer universal Pharmacare. Given these points, I devised a study which asked the following question: what messages can be found to inform the path forward regarding the LPC's proposal for a nationwide universal program of pharmaceutical insurance or 'Pharmacare' by comparing the Canadian approach to prescription drug coverage with that of the United Kingdom? The UK was selected as a comparator country because it shares key country characteristics with Canada. I applied a political economy lens to my inquiry and made use of the comparative approach. Canada and the UK were compared in three clusters (i) the levels and sources of expenditures on prescription drugs (ii) the levels and distribution of pharmaceutical insurance associated with prescription drug spending and (iii) the health outcomes "produced." The following sections present the messages found to inform the path forward on the LPC's Pharmacare proposal.

Rapid Approach to Pharmacare Implementation is Needed

A rapid approach is needed for the implementation of national Pharmacare by the federal government. The steps taken towards a Pharmacare inclusive Medicare system must be fast-tracked. The phased approach of Pharmacare (Figure 1) demonstrated in the Hoskins Report has the potential to impact Pharmacare policy development in Canada. Booth (2013) explained, the

expansion of Medicare into Pharmacare was the next logical step in health care coverage in Canada, however, when a piecemeal approach was taken towards it, the 'pace of change' deposited certain mechanisms and impacted its policy development. Pharmacare became lodged as an 'extra' in the minds of politicians, policy leaders, and after some time, the public (Boothe, 2013).

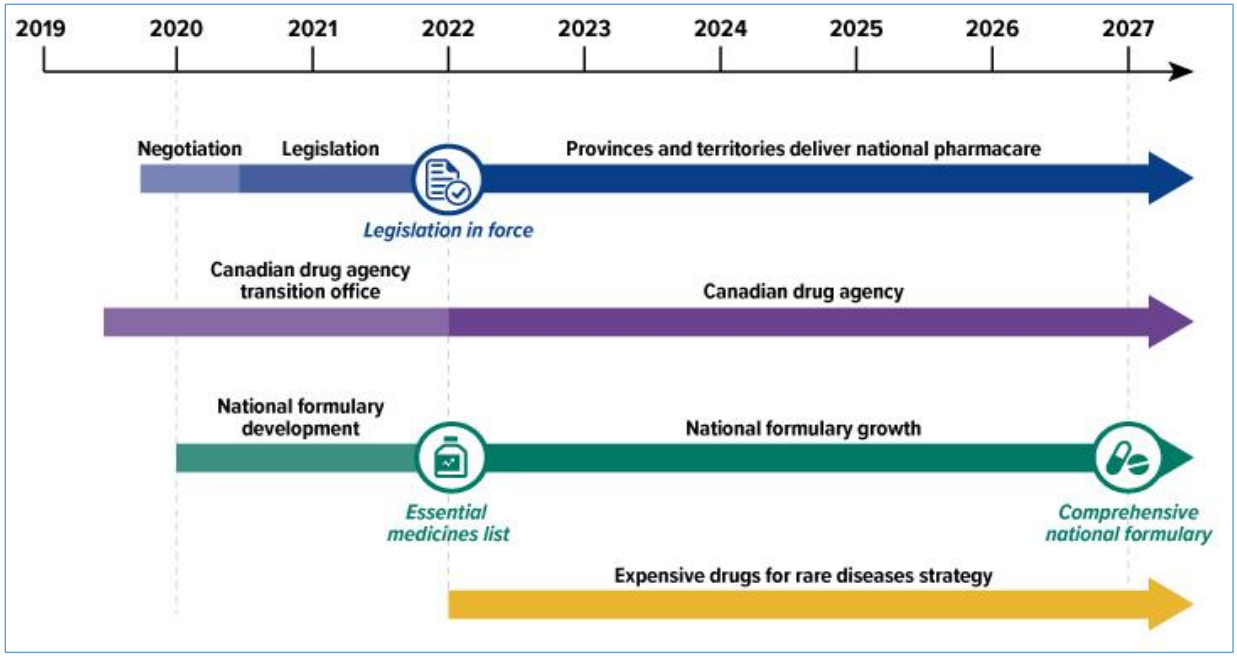

Figure 1. Timeline for Pharmacare Implementation, by Government of Canada (2019). This figure is a timeline beginning in 2019 and extending to 2027 that illustrates the phased approach of Pharmacare. There are four arrows representing the different aspects of Pharmacare that will evolve over time.

A rapid approach would concretely demonstrate to politicians, policy leaders and the public of today, Pharmacare is no longer an 'extra' when it comes to health care coverage in Canada. It would establish medicines are a public health good and should be a part of a public health insurance system. Under a phased approach the timeline for implementation is over seven years (Figure 1). Canadian residents would have to wait until 2027 for access to a comprehensive national list of medicines. There would be a five-year period in which access to medicines is

limited. Coverage for a resident may become restricted if a medicine prescribed is not on the 'essential medicines list'. The resident may have to supplement the lack of coverage in the form of out-of-pocket payments or private health insurance. The patchwork system for prescription drug coverage in Canada would continue to prevail until the comprehensive national formulary became operable.

My study showed the patchwork system for drug coverage in Canada is inequitable. Access to prescription drug coverage outside of the hospital setting may be restricted to a resident for several reasons out of their control. The portion of the population which pays for medicines out-of-pocket can only acquire the medicine(s) that fall within their budget. The resident may select to forgo their prescription entirely and several studies (Kennedy & Morgan, 2006; Law et al., 2021; Morgan & Lee, 2017; Law et al., 2018; Lopert et al., 2018) have been completed on residents being unable to fill a prescription due to cost [also know as cost-related nonadherence (CRNA)].

Kennedy and Morgan (2006) reported residents likely to report 'failing to fill a prescription due to cost' had inadequate insurance, young age, poor health, chronic pain and/or low household income. Law et al (2012) reported CRNA for 1 in 10 Canadians who received a prescription and concluded a main factor of this phenomenon was the variation in insurance coverage for prescription drugs. Additionally, Law et al (2018) reported cutting out prescription drugs, other necessities, and additional health care services was linked to out-of-pocket payments for medications.

Lopert et al (2018) estimated hundreds of early deaths in Canada due to the difficult experience residents have in paying for prescription drugs. Their report explained these premature deaths could be avoided if the resident had access to universal comprehensive

prescription drug coverage. Taken as a whole, the continuous inequities faced by residents under the patchwork system calls on the government to adopt a rapid approach rather than a phased approach to Pharmacare implementation. The implementation of Pharmacare in Canada should *overhaul* the patchwork system from the *outset*. *Public goods must be accessible to all rather than an 'extra.'* To further support this claim, below I provide my results from comparing the patchwork system in Canada with the universal, single-payer, public system of the UK.

Compared to English-Speaking OECD Country with Universal Pharmacare

Access to prescription drugs prescribed outside of the hospital setting has been standardized for UK residents across all populations and life stages. The National Health Service (NHS) in the UK provides a comprehensive range of health services under which prescription drugs prescribed inside and outside of the hospital setting are included. The comprehensive public health system in the UK was established early on through national health legislation. The legislation ensures necessary health services are delivered to the public. As cited in Boothe (2012), there is valuable scholarly literature describing this health policy change (Hacker 1998; Tuohy 1999; Klein 1995). The change paved the way for the effective development of drug coverage, pricing and financing (Morgan, 2018a). A list of medically necessary drugs or formulary is managed at the national level. To control the price of non-generic drugs a price regulation scheme is applied by the UK's Pharmacare system (Cylus et al., 2015). These strategies support the system to procure non-generic (branded) medicines at fair prices, promote a strong pharmaceutical industry and empower its residents.

The patchwork system in Canada contrasts that of the UK. The Canadian system is not organized at the federal level and residents across all populations and life stages do not access their coverage under an identical scheme. This system exists partly due to the incremental

approach to health policy adopted at the time when a comprehensive health service was proposed to the provinces by the federal government. Canada did not have the conditions for a rapid approach to health policy reform given the immediate postwar period (Boothe, 2012). The incremental approach to health policy reform ushered the patchwork system for prescription drug coverage observed in Canada today.

My comparison of the two systems in three specific clusters revealed several points directing to the reliability of a rapid approach (utilized in the UK) for health policy development and advancing equity in health. The UK spending per capita on retail pharmaceuticals was substantially lower than Canada for the period 2015-2017 (Table 1). The proportion of expenditures contributed from public funds was almost double that of Canada in the UK during this period (Table 1). Canada contributed below the OECD average in public funds respectively. The UK was able to spend less per capita on pharmaceuticals for this period while delivering access to prescription drug coverage to all its residents (Table 2).

Health spending per capita remained relatively high in Canada when compared to the UK (Table 2) and pharmaceutical spending as a percentage of health spending was higher in Canada compared to UK (Table 2). Per capita government health spending in Canada was slightly higher than the UK (Table 2). Despite the high health spending in Canada, cost appeared less a barrier in UK, about 2 times as many Canadian primary care doctors reported their patients had difficulty paying for medicines or out-of-pocket costs (Table 3). Finally, two times as many Canadians experienced a cost-related access problem to medical care (Table 3).

On the whole, Canada spends substantially more on pharmaceuticals, contributes less to public funds, and access to prescription drug coverage is restricted for segments of its population (Table 2). Lexchin (2020) explains, “one of the main reasons why other countries can keep their

spending so much lower than Canada's is because national drug insurance allows for monopsony buying power" (p. 529). Therefore, any identified problems with prescription drug coverage in Canada are not the result of low levels of spending and the contribution of public funds as a proportion of expenditures on retail pharmaceuticals, at the very least, should meet the OECD average (Table 1).

Health System Performance. Schneider et al (2017) compared the health system performance of eleven high income countries and reported Canada (9^{th}) ranked near the bottom on overall performance. Across five domains, care process, access, administrative efficiency, equity and health care outcomes, Canada scored lower than the eleven-country average. In measures related to equity of its health system, Canada demonstrated large disparities between lower and higher income adults (Schneider et al., 2017). The measures related to financial barriers, such as skipping needed doctor visits or dental care, forgoing treatments, or tests, and not filling prescriptions because of the cost, were considerable (Schneider et al., 2017). In contrast, the UK was one of the overall top-ranked countries in health system performance in this study by Schneider and colleagues (2017). Schneider et al (2017) state, "the UK achieves superior performance compared to other countries in all areas…" (Schneider et al., 2017, p.5). Moreover, the UK ranked first on measures related to equity of health systems (Schneider et al., 2017). Between lower-and higher-income adults in the UK the differences were smallest on eleven measures related to timeliness, financial barriers to care, and patient-centred care (Schneider et al., 2017).

The performance shortcomings of Canada cross more than one domain of health care whereas, the UK falls short in the single domain of health care outcomes despite having the largest reduction in morality amendable to health care during the past decade (Schneider et al.,

2017). Canada displays its top performance in care process and administrative efficiency ranking sixth overall (Schneider et al., 2017). The results of Canada are troubling given the high per capita health and pharmaceutical spending in relation to the UK (Table 2). Pharmaceutical spending as a percentage of health spending (Table 2) was high in Canada compared to UK. Schneider et al (2017) explain a top performing country such as the UK can provide benchmarks and helpful insights on how to improve care. The UK provides universal coverage and access suggesting high performance can be achieved through different payment and governmental approaches. In terms of implementation of Pharmacare in Canada, the LPC should adopt a rapid approach and cover a comprehensive list of medicines from the outset like the UK. The approach Canada takes to implementing Pharmacare is vital given the long history of proposals for the service at the federal level, the health inequities produced by the system, and the trends in health system performance.

COVID 19 Pandemic in Canada

The Angus Reid Institute (ARI), a national, not-for-profit, non-partisan public opinion research foundation, conducted a follow-up to their landmark study from 2015 which identified one-quarter of Canadian households were struggling to keep up with prescription drug costs (ARI, 2020). The follow-up study found that during a global pandemic which put a strain on the finances of Canadians, nine-in-ten households (89%) had been prescribed medications by a doctor and one-in-three (32%) had filled a prescription six or more times over the past year (ARI, 2020). This represents a seven-point increase from 2015 (ARI, 2020). Government support and insurance cover most or all the cost of prescriptions for majority of Canadians (72%) however, one-quarter (26%) is required to find money for half the cost or more on their own (ARI, 2020).

Furthermore, ARI (2020) reports, the rates of prescription drug coverage differ by gender and ethnicity. Partial coverage or no insurance was more likely reported by women and Canadians who identify as a visible minority. Persaud (2020) notes, because prescription drug coverage in Canada is associated with a good-paying job which usually extends health benefits to its employees, racialized Canadians and women are not as likely to work in these jobs than white Canadians and men. Pharmacare goes beyond health to delivering racial justice and gender equality (Persaud, 2020). The ARI (2020) study reported the inclusion of medicines in the publicly funded system is supported by people of all political stripes. The idea of Pharmacare is supported by nine in 10 Canadians, eight in 10 want their provincial governments to work with the federal government on implementation and seven in 10 claimed it should be a high priority for government even during the pandemic (ARI, 2020). Markedly, additional articles Lewis (2020), Hajizadeh and Edmonds (2020), and Lexchin (2020) were published in the *International Journal of Health Policy and Management* making the rational and logical case for Canada to adopt a universal public Pharmacare plan.

Recognizing Medicines as a Public Good for Pharmacare Implementation

The trends of high health and pharmaceutical spending have resulted in poor health outcomes for Canada including an inequitable PPharmacare system. Lewis (2020) describes the Canadian drug sector is in disarray and private interests surpass the public interest. He notes, "current policy and practice make a mockery of principles of Medicare, favour the strong over the weak, the prosperous over the poor, the suppliers over the patients" (p. 2). This description demonstrates medicines need to be established as a public good. Lewis (2020) further elaborates "universal Pharmacare requires a non-commercial, non-profit-maximizing ethos that views drugs as public goods rather than free market commodities" (p. 2). As a private good the profit motive

will continue to be emphasized benefiting the pharmaceutical industry rather than the health of those whose coverage for prescription drugs is out-of-pocket. The Hoskin's Report openly calls for universal single payer Pharmacare and is an immediate policy window for solidifying the public good nature of medicines in Canadian democracy (Quigley, 2017).

The incremental approach to Pharmacare implementation laid out in the Hoskin's Report is a health policy reform that is not dependant on time (Reich 1995, p.55). Reich (1995) explains "political timing provides opportunities for policy entrepreneurs to introduce ideas into the public debate…" (p.47). The Hoskins Report indicatively places Pharmacare on the political agenda creating a window of opportunity for a rapid approach. In terms of Pharmacare implementation in Canada, the idea which requires introduction into the public discourse is that medicines are no longer an 'extra' in health care coverage in Canada. The timeline for implementation is spread over several years and a comprehensive list of medicines will not be covered until 2027. Medicines aside from those on the essential medicines list will continue to be considered an 'extra' in health care coverage. The result of previous incremental approaches to this health policy reform assigned medicines as an 'extra' in the public discourse giving way to an untenable patchwork system for prescription drug coverage yielding poor health outcomes for the Canadian population. Lewis (2020) emphasizes that Pharmacare in Canada must be well designed. Implementation of Pharmacare in Canada spans five major political constituencies: (i) physicians (ii) chain pharmacies (iii) private drug insurers (iv) pharmaceutical industry and (v) public. Pharmacare implementation is both a civic and technical challenge according to Lewis (2020). It will require good policymaking, balance of interest, and collective commitment to the public good (Lewis, 2020).

Dangers of Gradual Pharmacare Implementation. It is important to note the dangers of gradual Pharmacare implementation in Canada provided the messages above. First, an inequitable system for prescription drug coverage will continue for an overdue amount of time. Pharmacare is one of the many services Medicare understood it would provide to residents down the line. However, 80 plus years to provide this service, questions the ability of the health system, and the policies that go along with it, the ability to evolve and innovate. Health in the realm of prescription drug coverage outside of the hospital setting is unachievable for population groups with identifiable characteristics. Members of a democracy require an equal opportunity to achieving health as stated in Article 25 of the United Nations (1948) *Universal Declaration of Human Rights* that "everyone has the right to a standard of living adequate for the health and well-being of herself and of her family, including food, clothing, housing and medical care and necessary social services." The role of medicines in the health of residents has significantly changed since public health insurance was established in 1966. An array of medicines is available on the market for several health interventions. Therefore, those residents that continue to lack prescription drug coverage are unable to fully exercise their right to health.

Next, the health system performance of Canada will continue to diminish. The trends in health and pharmaceutical spending will continue to increase. It is vital that health systems strive for sustainability given they are publicly funded with limited resources. Finally, the concept of nationwide Pharmacare may become tougher to dislodge as an 'extra' from the minds of politicians, policy leaders and public. An expensive national program requires buy-in from a depth and breadth of stakeholders and the current window of opportunity to introduce the comprehensive program will not be available after a certain period.

Barriers to Implementing Nationwide Pharmacare. It is important to be aware of the barriers to implementing nationwide Pharmacare. My inquiry demonstrates three persistent barriers: (i) federalism in Canada (ii) the Constitution of Canada and (iii) pharmaceutical companies (hereinafter Big Pharma). First, the federal system of government gives way to the two orders of government which are the provincial and federal governments. The Constitution of Canada defines the division of powers between the two governments. Also, for each government to maintain their areas of autonomy, the constitution sets out the division of revenue sources (Government of Canada, 2021). Provincial governments are responsible for the *delivery* of health care in Canada and to receive a full federal cash contribution (Canada Health Transfer) each province must meet the criteria and conditions (universal coverage, comprehensiveness, public administration, transferability, accessibility) set under the Canada Health Act (CHA). The federal system in Canada is decentralized, and power, authority, financial resources, and political support are shared substantially among the two levels of government (Simeon, 2013). Simeon (2013) states, "it is often said that the provinces' strength may make Canada the world's most decentralized federal country, and that Canada has resisted economic and social forces which increased centralization elsewhere." As a result, the implementation of nationwide Pharmacare by the federal government will have to go up against these mechanisms. The development of federal legislation which would enshrine the principles and national standards of Pharmacare, separate and distinct from the Canada Health Act, will need to be negotiated with the provinces. The federal government would need to ensure provinces agree to (i) the standards and principles of the program (ii) a governance plan and (iii) financing arrangements (Government of Canada, 2019). The makeup of provinces in Canada are non-identical and to have the legislation meet the needs of all provinces will prove challenging. There is a very real possibility in a decentralized

federal state for this proposed program to get trapped in negotiations between the two governments.

Big Pharma has clinched this policy space through their expression of maintaining high drug prices for pharmaceutical innovation, research, and development (R&D) (Mohamed & Chaufan, 2020). This was reflected in the ending of compulsory licencing from Canada's Patent Act and intellectual property rights (IPRs) by the federal government and then subsequent ratification of the North American Free Trade Agreement (NAFTA) in 1993 (Mohamed & Chaufan, 2020). Patented drugs are produced by competitors without the consent of the patent holder under compulsory licencing (Mohamed & Chaufan, 2020). In turn, this challenges any drug monopolies and lowers drug prices (Mohamed & Chaufan, 2020). IPRs on the other hand, extend the protection of patents and guard competition to the patent holder thus increasing drug prices (Mohamed & Chaufan, 2020). As cited in Guennif (2017), "industry alleged that unless compulsory licensing was eliminated, its profitability would be threatened, which in turn would decrease its ability to afford necessary and costly R&D (Mohamed & Chaufan, 2020, p.2). It was shown earlier in this paper, pharmaceutical drug spending is high in Canada and the cost of drugs prescribed outside of the hospital setting are a key barrier to reaching an equitable health care system respectively (Mohamed & Chaufan, 2020). There is a persistent tension between public needs and corporate interests at the pharmaceutical policy level and this has been richly demonstrated by Dr. Joel Lexchin in his latest book *Private Profits versus Public Policy: The Pharmaceutical Industry and the Canadian State.*

Conclusion

The goal of this section has been to present the key messages derived from my study to inform the path forward on the LPC's Pharmacare proposal. The overarching message was that a

rapid approach is needed for the implementation of national Pharmacare by the federal government. The approach taken will be crucial given the long history of proposals for the service at the federal level. The steps laid out in the Hoskins Report need to be accelerated since several findings indicated poor trends in health system performance and production of health inequalities under the current system for prescription drug coverage in Canada. A rapid approach to Pharmacare implementation covering a comprehensive list of medicines from the start goes beyond just delivering a health provision but racial justice and gender equality (Persaud, 2020). Access to prescription drug coverage in Canada is commonly limited in these population groups: women, BIPOC, part-time employees, low-wage earners, and those under the age of 25. A rapid approach helps to establish medicines are a public good and pertinent to a democracy rather than just a free-market commodity under capitalism. The Hoskins Report concretely places Pharmacare on the political agenda, creating a window of opportunity for the federal government to employ a rapid approach for Pharmacare implementation since policy change requires careful consideration of timing (Reich, 1995, p.54).

Future Action

As of April 1st, 2021, the Government of Canada is in its infancy of implementing nationwide Pharmacare. A Health Canada news release stated, "the Government of Canada is taking concrete steps to establish the foundational elements of national, universal Pharmacare" (Government of Canada, 2021). The head of the Canadian Drug Agency Transition Office was also announced (Government of Canada, 2021). The office has four main purposes (i) advance Pharmacare-related initiatives (ii) support federal-provincial territorial discussion through leadership and resources (iii) engage provinces, territories, and stakeholders on the creation of a new Canadian Drug Agency and (iv) work closely with partners to develop a national formulary

(Government of Canada, 2021). Stunningly, there was no mention of legislation in the news release. The timeline for Pharmacare implementation in the Hoskins Report displays legislation to be prepared during 2021 and then come into force in 2022 (Government of Canada, 2019). The Hoskins Report stated, "legislation would reassure provinces and territories that the federal government has an enduring commitment to national Pharmacare which the premiers told us was vital" (Government of Canada, 2019, p.97). With the absence of the mention of legislation in the news release it brings into question the commitment of the LPC to national Pharmacare. If national Pharmacare is to work, the standards and financing agreements to which the federal government, provinces and territories will be held to must be formalized (Government of Canada, 2019).

The steps towards the implementation of Pharmacare by the federal government are continuing as incremental. This raises concern for any success in the reduction of health inequalities by the program. Future research should pose the following questions: Is reducing health inequalities politically feasible by the federal government when a window of opportunity is available? How long must the imagined window of opportunity be for tackling health inequalities at the federal level? Schrecker (2017) explains these kinds of questions are fundamental to developing a political science of health inequalities and the importance of the project has been identified by several authors (Bambra, Fox, and Scott-Samuel, 2005; Bernier and Clavier, 2011; de Leeuw et al., 2014; Participants, 2015; Lynch, 2017).

He explains work related to this project has usually highlighted: (a) content of official policy documents (b) organizational structure of government (c) participant views in policy process or (d) the relationships between left-right partisan orientation, structure of the welfare state and health outcomes (Schrecker, 2017). Largely, this paper has highlighted this type of

content. In section one, I demonstrated Canada is the only mature welfare state to lack broad coverage of medicines and there were several proposals for nationwide Pharmacare available at the federal level, the most recent of which was the Hoskins Report. Section two then reviewed the federal proposals for Pharmacare in Canada from 1943 to 2019. To extract any messages to inform the path forward on the most recent proposal for nationwide Pharmacare in Canada, I undertook the comparative approach and applied a political economy lens. This method and methodology were outlined in section three and four. Next, I compared the Canadian approach to prescription drug coverage with that of the United Kingdom. Section five and six explored those approaches.

Given the differing approaches in each country, in section seven I compared the performance of each country in three clusters. Canada demonstrated higher levels of pharmaceutical and government health spending compared to the UK and yielded poorer health outcomes. Finally, section eight presented the key messages brought forward by my inquiry. I argued a rapid approach is needed for the implementation of national Pharmacare by the federal government and the steps taken towards a Pharmacare inclusive Medicare system must be fast-tracked. Under the patchwork system in Canada, residents continue to face inequality in health. These residents belong to certain population groups and have identifiable characteristics. The rapid approach would help to establish medicines are a public good and valuable to a democracy. A window of opportunity is available at the federal level to take up this rapid approach, catapult Pharmacare policy development and reduce health inequalities. To close, there is a need to address the political core of my argument and future research should address these unresolved questions: “why particular official actors or electorates have the policy preferences that they do and how institutional frameworks influence the pathway from those preferences to the control of

the government" (Schrecker, 2017, p. 294). The questions offer a sophisticated way of understanding the political feasibility of reducing health inequalities in a jurisdiction (Schrecker, 2017). For those of us committed to reducing health inequalities, the questions of political feasibility are of utmost importance (Schrecker, 2017).

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Appendix A

Pharmaceuticals: Understanding the Terms

Pharmaceuticals	Form part of the International Classification of Health Accounts of Health Care Functions (ICHA-HC) which defines health care goods and services. This is subdivided into prescribed medicines, over the counter (OTC) medicines and other non-durables.	
	Prescribed Medicines	Are medicines supplied only in licensed pharmacies on the presentation of signed prescriptions issued by a licensed and registered medical practitioner, licensed and/or registered dentist (for dental treatments only) and the supply and dispensing of these medicines must be carried out by a pharmacist or under the supervision of a pharmacist.
	Over-the-Counter (OTC) Drugs	OTC drugs may be dispensed without a prescription. In some countries they are available via self-service in pharmacies and/or other retail outlets (e.g. drugstores or supermarkets).
	Reimbursed Drugs	Medicines whose cost is covered by a third-party payer (e.g. Social Health Insurance/National Health Service).
	Other Non-Durable Goods	Include bandages, plasters, syringes, etc. Account for only a minor share of the overall pharmaceutical and non-durable medical goods total – typically around 5-10%.
Retail Pharmaceuticals	The categories of pharmaceuticals above refer to retail pharmaceuticals, delivered to patients via pharmacies and other retail outlets.	
	Hospital Inpatient Sector	Pharmaceuticals are also consumed in other care settings, primarily the hospital inpatient sector. Within this sector, pharmaceuticals are considered as an input to the overall service treatment and not separately accounted.
	Total Pharmaceutical Spending	Reported as an additional item in health account reporting. Total pharmaceutical spending covers all modes of pharmaceutical delivery.
Purchasing Power Parities	For international comparisons, purchasing power parities (PPPs) are spatial deflators and currency converters that take into account and eliminate the effect of different price levels thus allowing comparisons of spending in a common currency – in this case US dollars.	

Source: Belloni et al 2016 & PPRI Glossary.

Appendix B

Health and Pharmaceutical Spending Indicator Defined

Health Spending	Measures the final consumption of health care goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments	
	Financing	Health care is financed through a mix of financing arrangements including government spending and compulsory health insurance as well as voluntary health insurance and private funds such as households' out out-of-pocket payments, NGOs and private corporations.
	OECD Indicator	This indicator is presented as a total and by type of financing and is measured as a share of GDP, as a share of total health spending and in USD per capita (using economy-wide purchasing power parities (PPPs).
Pharmaceutical Spending	Covers expenditure on prescription medicines and self-medication, often referred to as over-the-the counter products. In some countries, other medical non-durable goods are also included. Pharmaceuticals consumed in hospitals and other health care settings are excluded. Final expenditure on pharmaceuticals includes wholesale and retail margins and value-added tax.	
	Total Pharmaceutical Spending	In most countries, refers to "net" spending, i.e. adjusted for possible rebates payable by manufacturers, wholesalers or pharmacies.
	OECD Indicator	This indicator is measured as a share of total health spending in USD per capital (using economy wide PPPs) and as a share of GDP.
Purchasing Power Parities	For international comparisons, purchasing power parities (PPPs) are spatial deflators and currency converters that take into account and eliminate the effect of different price levels	

	thus allowing comparisons of spending in a common currency – in this case US dollars.

Source: OECD (2020) Health and Pharmaceutical spending indicator; Belloni et al.