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Ontario Medical Students Association
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POSITION PAPER

Pharmacare Now!: A Prescription for Equity

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KEY POINTS

- Canada remains the only high-income country with a universal healthcare system that does not include a universal drug plan.
- The current patchwork of provincial and federal regulations leaves at least 1.5 million Ontarians without any access to prescription coverage.
- Evidence shows that even a $5 charge for a prescription can lead to cost-related medication non-adherence, and that tens of thousands of Canadians experience increased morbidity and mortality each year from a lack of access to medications.
- The federal government's proposals and commitments to implement pharmacare date back to the 1940s, but they have failed to take definitive action.
- In the absence of a national pharmacare plan, the provincial government is well-positioned to implement its own prescription drug coverage.
- Drug spending is the fastest growing component of healthcare spending in Canada, rising from $2.6 billion in 1985 to $33.7 billion in 2018.
- Retail drug prices in Canada are among the highest in the OECD countries, and up to four times higher than the best available prices in the OECD.
- A national pharmacare program is estimated to save the economy between $4 billion and $11 billion per year.
- The recently-announced Confidence and Supply agreement was reported to include the implementation of pharmacare, but the fine print of the agreement actually promises very little, and the government has subsequently reversed other measures aimed to increase access to medication.

PUBLIC DRUG INSURANCE IN CANADA

Canada remains the sole high-income country in the world with an established public health care system that does not include coverage for medically necessary prescription medications. Many countries, including Germany, France, Australia, Switzerland, Austria, Italy, Spain, Sweden, the Netherlands, Norway, New Zealand, the United Kingdom, and Denmark, provide both universal healthcare and pharmacare (1). This is not an oversight, but a deliberate choice in healthcare spending.

Most hospital and physician services in Canada are funded through a blend of federal transfer payments (often called “Medicare”) and insurance plans operated by each province and territory(2). Medicare, established under the Canada Health Act (the “Federal Act”), helps ensure the same basic level of healthcare is available across the country, by tying federal funding to specific health policy objectives. At a high level, the Medicare program requires provinces to insure (i.e., fund) a basic level of health services in order to be eligible for federal health transfer payments under the Federal Act–a large portion of provincial healthcare budgets (3). This is the basis for Canada’s universal healthcare system and the most likely vehicle for funding a national pharmacare program.

Currently, the Federal Act requires the provinces to provide prescription coverage for drugs administered in a hospital. This comes from the definition of “insured health services” (those services a province must insure to receive Medicare payments), which includes drugs (a) “administered in the hospital”, which are (b) “medically necessary for the purpose of maintaining health, preventing disease, or diagnosing or treating an injury, illness, or disability” (3).

For its part, the Ontario Health Insurance Act (the “OHIP Act”) implements this federal mandate through the Ontario’s Health Insurance Plan (“OHIP”). Like the Federal Act, the OHIP Act (or, more specifically, its General Regulations (4) limits prescription drug coverage to drugs administered in a hospital, as part of either in- or out-patient services. The Act goes a step further and specifically clarifies that OHIP does not cover “the provisions of medication for the patient to take home” or “visits solely for the administration of drugs, vaccines, sera or biological products”(4). In other words, a drug not delivered in the in-patient setting must be administered as part of an out-patient treatment or investigation to be covered by OHIP–and that treatment cannot simply be the administration of the drug.

Collectively then, both federal and provincial healthcare policy ensure publicly-funded prescriptions are available in hospital settings. However, both policies also require that a drug be “administered in the hospital” to receive coverage–a restriction that deliberately excludes the vast majority of prescriptions Canadians take at home. In those cases, coverage must either come from a specific federal or provincial drug program (discussed below), private insurance, or an individual’s own funds.

The implication of such policies is that coverage in the community is significantly more limited, and largely depends on the identity of the individual receiving the medication, in contrast to the relatively universal drug coverage in hospitals. In that regard, over the past few decades, the federal and provincial governments have established a dizzying array of drug programs aimed at providing coverage to members of specific, eligible groups. A detailed review of each program is beyond the scope of this paper; however, a general understanding of the main programs and their eligibility requirements is important to comprehending the limits of current prescription drug policies.

Federal Drug Benefit Programs

At the time of writing, the federal government operates six main drug plans through various branches of government. Eligibility for each plan is premised on establishing membership within a specific federally “regulated” group. The exact requirements for each program are, at times, quite complex, as are the formularies for determining which drugs are or are not covered. Nonetheless, generally, federal programs cover the following individuals:

Federal Plan	Eligible Group
Indigenous Services Canada, First Nations and Inuit Health Branch, Non-Insured Health Benefits (5)	Federally registered/recognized members of First Nations or Inuit communities and children of such individuals under 18 months of age.
Canadian Forces Drug Benefit Plan (6)	Currently enrolled members of the Canadian Armed Forces and, in some circumstances, their dependents, along with certain civilian military personnel.
Veterans Affairs Canada, Treatment Benefits Program (7)	Certain current or former members of the Canadian Armed Forces, certain current or former members of the Royal Canadian Mounted Police, Second World War or Korean War Veterans, and certain civilians who served in the Second World War.
Royal Canadian Mounted Police Health Benefits Program (8)	Members of the Royal Canadian Mounted Police
Citizenship and Immigration Canada, Federal Health Program (9)	Resettled refugees, protected persons in Canada, refugee claimants, victims of human trafficking, and individuals detained under the Immigration and Refugee Protection Act while in detention.
Correctional Services Canada, Health Services (8)	Individuals incarcerated in a federal correctional institution

In addition to specific prescription drug programs, the federal government also provides prescription coverage to many of its public sector employees – coverage which is arguably also at least partially public.

Ontario's Provincial Drug Benefits Programs

Like the federal system, Ontario's public prescription coverage is a patchwork of different community programs. Of these programs, the largest is the Ontario Drug Benefit ("ODB") (10), which provides coverage to the following groups:

- Individuals entitled to receive drug benefits under the Ontario Disability Support Program Act, 1997, and the Ontario Works Act, 1997; and
- Individuals who are "insured persons" under the OHIP act and are:
    - 65 years of age or older;
    - 24 years of age and under who do not have a private insurance plan (i.e., "OHIP+");
    - Receiving certain professional services provided or arranged for under the Home Care and Community Services Act, 1994;
    - Residents of Long-Term Care homes;
    - Residents of Homes for Special Care or Community Homes for Opportunity; and

- Enrolled in the Trillium Drug Program (11).

The Trillium Drug Program (the "Trillium Plan") is somewhat unique among the ODB, in that it provides so-called "catastrophic drug coverage" to Ontario residents whose medication costs exceed a certain percentage of their household income (12).

In addition to the ODB and Trillium Plan, Ontario also offers condition-specific drug coverage through four separate programs: the (a) Special Drugs Programs, (b) New Drug Funding Program for Cancer Care, (c) Inherited Metabolic Disease Program, and (d) Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program (13).

Issues with the Current System

Despite the numerous plans provided by the federal and provincial governments, many Canadians do not have access to fully-funded prescription coverage. Indeed, it is estimated that nearly 1.5 million Ontario workers lack any form of drug insurance at all (14). And even for those residents who hold private insurance, many must still pay copayments or deductibles, or have a limit on how much they can claim (15).

The greatest burden of Ontario's patchwork of inadequate public and private drug plans falls on those without access to a private insurance plan through a corporate employer, as well as those unable to afford prescription drugs. This is a sizable number of people: evidence shows that at least 25% of Canadians across the country have reported difficulty paying for prescription medication (16). That proportion has likely increased in light of the COVID-19 pandemic as higher rates of employment loss, unemployment, and self-employment have resulted in a reduction of drug coverage (16). Indeed, Canadians paid $32.7 billion in prescription drug costs in 2020, a number which has continued to rise and has left 40% of Canadians worried about their ability to afford their medications (17).

Nonetheless, the cost of inadequate prescription coverage extends beyond a simple dollar amount. The high price of prescription medications acts as a barrier to medication adherence. A study conducted by the Angus Reid Institute in 2015 found that 23% of Canadians did not fill or renew a prescription in the past year due to cost (18). Evidence has shown that even having to pay $5 for a prescription can lead to non-adherence to medication (19). The Angus Reid 2015 survey was repeated in 2020, and showed no improvement in the ability to afford prescription medications (20). Further, this study suggests that this lack of access is likely to worsen over time with more than 44% of Canadians being concerned that they may not be able to afford their medications in ten years, and only 24% being confident in their ability to finance their prescription needs (20). In the year leading up to this 2020 poll, Canadians were twice as likely to have lost prescription drug coverage (14%) than to have gained it (7%) (20).

A similar survey from Statistics Canada reported that 23.5% of Canadians did not have coverage for their medication costs. Although some Canadians have drug plans, over 25% reported still having to pay half or more of the cost of their prescription drugs. In low socioeconomic status households, this statistic rose to 37% (20).

At its most striking, it has been estimated that a lack of access to pharmacare is responsible for hundreds of premature deaths (21). In part, this is because the inability to afford medications leads to not filling, or inappropriately rationing, prescriptions that are necessary to prevent morbidity and mortality. Every year, inadequate drug coverage results in approximately 370 to 640 Canadians dying prematurely due to ischemic heart disease, 270 to 420 due to diabetes, and 550 to 670 older adults prematurely due to all causes (21). As well, up to 70,000 older adults experience avoidable health deterioration, due to lack of access to medications (21).

To make matters worse, the harms caused by inadequate prescription coverage are often experienced by already vulnerable populations such as those with poorer health, lower socioeconomic status, no private insurance, multiple comorbidities, and elderly, female, and younger persons as well as

those unable to work (22,23). These populations are more likely not to have private drug plans and be forced to pay out-of-pocket for prescription drugs as well as to experience non-adherence, higher healthcare service use, and to have to compromise on other necessary expenses (23). The significant cost of prescription medications often results in foregoing spending on essentials like food and heat to pay for prescriptions (23). Even for people with private coverage, additional payments in the form of deductibles, co-payments, and risk-rated premiums place a disproportionate burden on those with significant and chronic health needs (1).

There is good news, however: a study by Persaud et al. in 2022 (24) ascertained that free distribution of prescription medications increased adherence to therapy, timely renewal of medications, and ability to afford other expenses. In turn, these led to improved health outcomes related to cardiovascular events, blood pressure readings, and diabetic control. It is estimated that appropriate use of prescription drugs, which could be achieved through cost-free medication as evidenced in this trial, could prevent 1 in 6 hospitalizations (24). In other words, we know how to mitigate the consequences caused by the inability to afford medications: the implementation of a public pharmacare system. There are public, political, and economic incentives to enact such a system now.

THE CASE FOR PHARMACARE

Public Support

Canadians have repeatedly affirmed their overwhelming support for pharmacare. A 2019 poll conducted by the Heart & Stroke Foundation and the Canadian Federation of Nurses Unions (25) found that 93% of Canadians believe it is important that everyone in Canada have equal access to prescription drugs, and 88% specifically support a national pharmacare program. In 2020, a poll from the Angus Reid Institute (20) similarly found that 86% of Canadians support a national pharmacare program to provide universal access to prescription drugs, while 77% also agree that increasing coverage should be a high priority for government. A poll by the same organization in 2015 had similar findings, with 91% of Canadians supporting universal drug coverage, regardless of province, age group, sex, education, or income level (18).

Support for pharmacare is also shared by the communities and constituencies which OMSA seeks to represent. In Ontario, the previous Liberal government introduced the OHIP+ program, which funded drug costs for those under 25. While falling short of universal pharmacare, this represented a significant expansion of Ontario's public drug coverage. Polling conducted during the 2019 provincial election found a strong majority (72%) of the public supported the policy. This support crossed political party lines, with 60% of decided Progressive Conservative (PC) voters and 79% of New Democratic Party (NDP) voters approving of the program (26).

As the next generation of physicians, medical students also overwhelmingly support pharmacare. A poll of 761 medical students by the Canadian Federation of Medical Students (CFMS) in 2019 found that 96% of respondents supported a national pharmacare policy, 55% felt the program should be truly universal without regard for income or insurance status, and 92% supported amending the Canada Health Act to ensure that public coverage for drugs meets the same standards as public coverage for medical care (27).

The demonstrated public support for pharmacare begs the question: Why, in our democracy, has no government enacted such a popular policy? Scholars like Hajizadeh and Edmonds (2020) point to "a lack of electoral incentives and general concern over costs to be incurred by government" (28). Lewis (2020) argues that, while huge numbers of Canadians want and would benefit from universal pharmacare, they are disenfranchised and"politically powerless, too busy deciding between groceries and drugs to mobilize" (29). He notes that government employees with the power and responsibility to address this problem are provided extended health benefit plans, paid for with taxes extracted from "the non-unionized working poor, the not quite indigent elderly, [and] struggling small business owners" (29) who go uninsured. Lewis also identifies five political constituencies important to pharmacare. The first two –

physicians and the public – stand to benefit from its implementation, although some may need to change their daily practice of prescribing or lose established private coverage. The other three – the retail pharmacy industry, private drug insurance, and pharmaceutical companies – stand to lose due to lower profit margins. As such, these latter stakeholders are incentivized to lobby aggressively to protect the status quo. As Lewis writes,

> "Pharmacare is redistributive, and if sensibly designed it will be anathema to those who profit from the prevailing illogic and inefficiency. They will energetically protect their interests, either by stalling pharmacare in its tracks or chipping away at the implementation plan until it no longer resembles the original. They are sophisticated, well-connected, and rich. They know how to push politicians' buttons and convince the public that no government plan could treat them as well as the pharma-private insurance alliance" (29)

It may be that these private interests have, until now, outweighed the public's astounding support for pharmacare in our leaders' political calculus.

Economic Considerations

It is a common assumption that pharmacare would be too costly to be practical. However, independent experts and government analyses have shown that pharmacare would save the Canadian economy billions of dollars through a combination of lowered drug prices, administrative efficiencies of scale, and cutting out private profit. This section will examine the potential economic effects of a pharmacare program.

Costs to the Public

Perhaps the most significant cost savings of pharmacare would be experienced by individuals and families relieved of out-of-pocket drug expenses and private insurance premiums, copayments, and deductibles. Out-of-pocket drug expenses account for 17% of drug spending in Canada, or $4.7 billion dollars, according to the Parliamentary Budget Office (PBO) (figure) (19). Other estimates place this figure at $6 billion, or 22% of total spending (1).

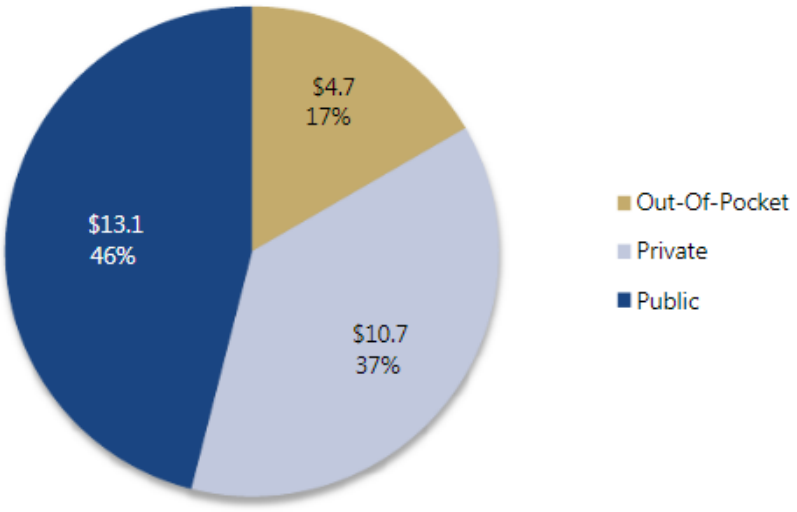

Fig. 1. "Non-Hospital Drug Spending in Canada, by Primary Payer, 2015-16 ($ Billions)" (19)

Currently, one in five Canadian households spend $500 or more per year on prescriptions, while nearly one in ten spend $1000 or more (1). Treatment with new and specialty drugs can cost tens or hundreds of thousands of dollars per year (1). While they accounted for negligible expenses 15 years ago, high cost drugs represented more than 25% of private drug spending in 2015 (1). An analysis of Statistics Canada household spending data from 2010 to 2015 demonstrated that out-of-pocket drug expenses account for more than half of mean out-of-pocket health expenses in almost every province in Canada. Mean equivalized out-of-pocket drug expenses were higher in Ontario than in Newfoundland, PEI, Nova Scotia, New Brunswick, Quebec, and the national average (28).

In Ontario, 15% of households were found to have "catastrophic out-of-pocket drug expenses," which are defined as drug expenses that exceed 3% of total household income. For 5% of households, expenses exceeded 6% of household income (28). There was an inverse relationship between socioeconomic status and catastrophic out-of-pocket drug expenses observed in all provinces, implying that the poorest pay proportionally more for their medications (figure 2) (28).

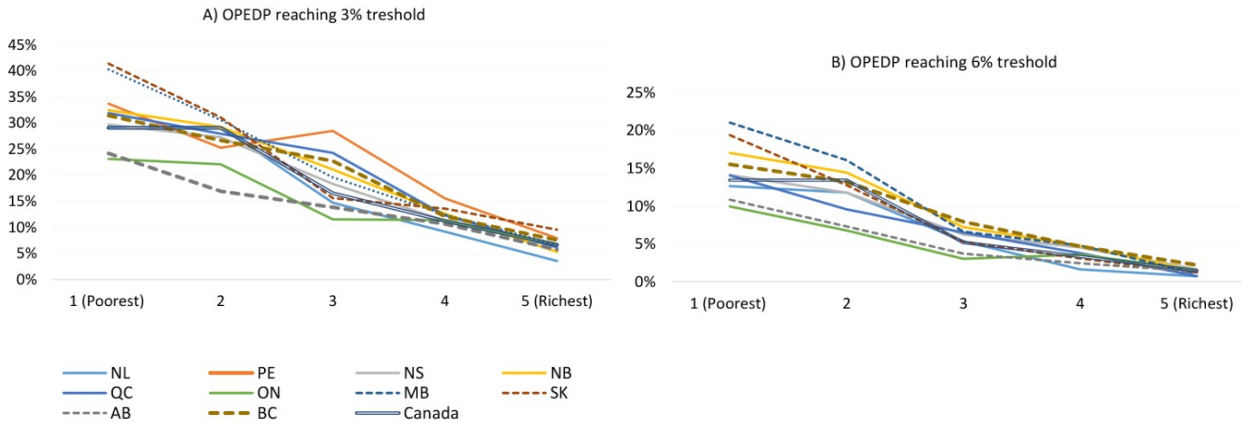

Fig. 2. "Proportion of Households With [Catastrophic Out-Of-Pocket Expenses on Drugs and Pharmaceutical Products] in 5 SES Quintiles Across Canadian Provinces Between 2010 and 2015." OPEDP is out-of-pocket expenses on drugs and pharmaceutical products (28).

Parliamentary Budget Office modeling for a national pharmacare program based on Quebec's model found that expansion to a national program would save patients across Canada a total of $3.6 billion dollars (19). The Quebec model includes copayments for some patients, but modeling showed that household out-of-pocket drug expenses would decrease by more than 90% on average under pharmacare. Patients ineligible for exemptions, paying maximum copayments under this model, would still save more than 69% of their current drug expenses. Reducing the costs of prescription drugs for individuals and families could have wide-ranging benefits to society, not limited to economic stimulation and mitigating the harms from cost-related treatment non-adherence, which will be explored later in this paper.

Costs to the Economy

Pharmacare has the potential to increase efficiency and save money that could be put to use elsewhere in the economy. In aggregate, Canadians spend an estimated $28.5 to 30 billion annually on outpatient pharmaceuticals (1,19). In 2015, this was more than twice the amount spent on dental care (i.e., $13 billion) and nearly equal to the total spent on physician services (i.e., $33 billion). Drug spending has risen dramatically in recent years, from $2.6 billion in 1985 to $33.7 billion in 2018 (30). Growing at a rate of 5.1% annually from 2004 to 2014, faster than in other OECD countries (22), it is the fastest growing component of healthcare spending in Canada (1).

Some of these costs represent inefficiencies without direct benefit, such as the estimated $1- to 2-billion administrative cost of the unnecessary duplicate administration of public and private plans (22).

These figures fail to capture more nuanced losses, including the inefficiencies created in the Canadian labour market when workers make decisions about their work and retirement based on availability of employer-sponsored drug coverage (22).

Potential Savings

It is estimated that a national pharmacare program would save the Canadian economy between 4 and 11 billion dollars per year (1). Analysis by Morgan et. al (31) predict a savings of $7.3 billion, or 32% of total spending. They analyzed several scenarios, with a worst-case savings of $4.2 billion (19%), and a best-case scenario savings of $9.4 billion (42%). Modeling by the Parliamentary Budget Office did not take into account administrative savings and lies at the lower end of this spectrum, projecting savings of $4.2 billion per year, or 15% of total spending by their analysis.

An important portion of these costs and savings is directly related to retail drug prices. Patented medications in Canada cost 18% than the average among other OECD countries, and four times more than the best available prices in the OECD (32). In a comparison of 33 OECD countries' drug prices, Canada's were higher than all but three countries, the United States, Switzerland and Germany (figure 3) (32).

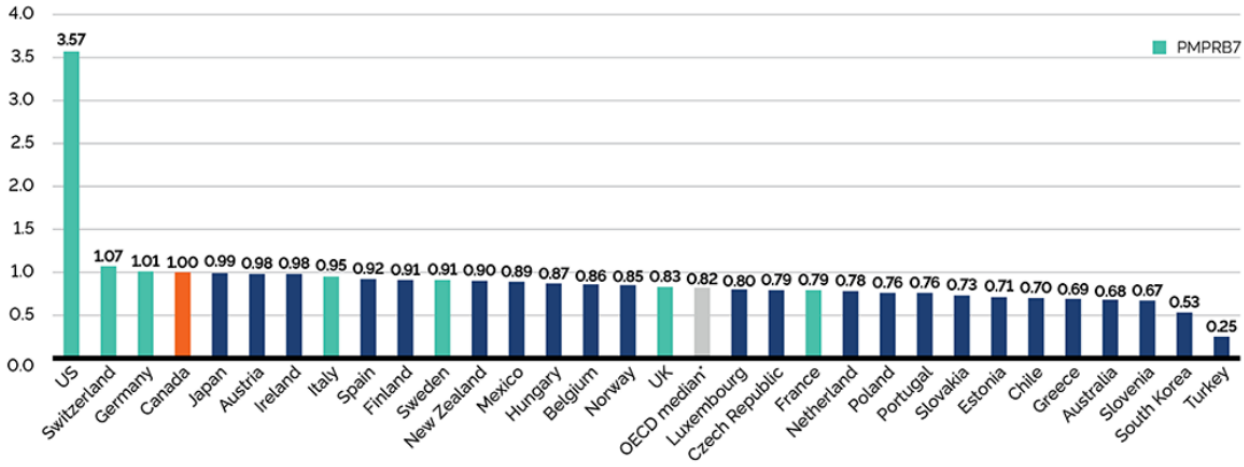

Fig. 3. "Average Foreign-to-Canadian Price Ratios, Patented Medicines, OECD, 2020" (32)

Medications are getting more expensive. In 2020, the median annual treatment cost for the 20 top-selling medications in Canada was $19,420, nearly 50 times the median in 2006 (figure 4) (32). Prices are also highly variable within Canada, with patients paying anywhere between $74 and $1332 for medication to manage congestive heart failure depending on patient age and province of residence (27). A universal pharmacare program has the potential to both lower and standardize costs, as a single purchaser has greater negotiating power to secure lower prices from drug manufacturers than individual drug plans. The Parliamentary Budget Office predicted a national pharmacare program would allow the government to set drug prices 25% lower than the lowest price currently available to public and private insurance plans (19).

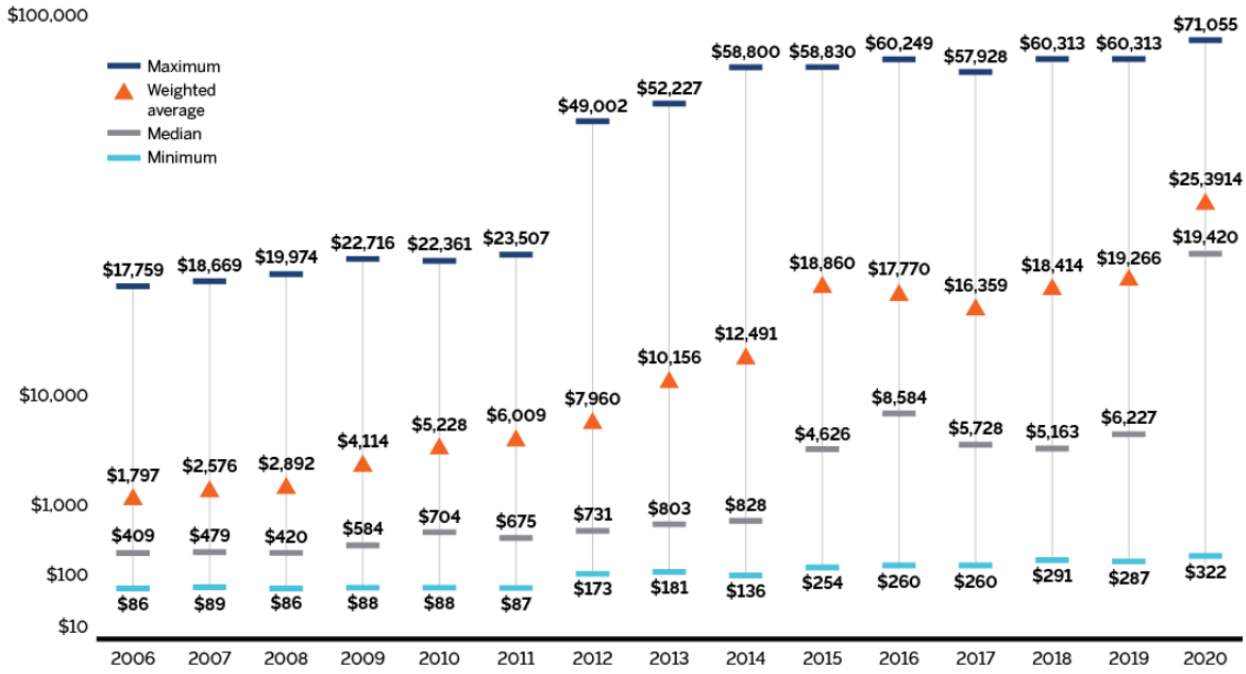

Fig. 4. “Annual Treatment Costs for the 20 Top-Selling Patented Medicines, 2006 to 2020” (32)

Universal pharmacare carries increased costs to the government, which must administer and fund the program. General concern about the public cost of a pharmacare program has been a barrier to political action on this front (28). The Parliamentary Budget Office estimates that the public sector would have to incur costs of $7.3 billion per year to yield savings of more than $4.2 billion annually to the economy as a whole (19). Other analyses have found that the cost of a national pharmacare program could cover a formulary of essential medicines without raising taxes (27). It is important to note that under pharmacare, businesses would in many cases no longer need to administer private drug insurance plans. These potentially significant cost savings could be taxed to support pharmacare, reinvested in pharmaceutical research and development, or put towards other health-promoting programs.

MEDICAL STUDENT ADVOCACY

Medical student organizations have a strong record of advocating for evidence-based health policy reform. In particular, the Canadian Federation of Medical Students (CFMS) has strongly advocated for pharmacare for over 13 years to date. Position papers calling for pharmacare have been adopted by the organization five times, in 2009 (33), 2014 (34), twice in 2015 (22,35), and most recently in 2019 (27). Medical students brought pharmacare to Parliament Hill in meetings with MPs as part of three CFMS lobby days in 2014, 2016, and 2019. Most of these initiatives advocate for pharmacare as a solution to the inaccessibility of prescription drugs, while some argue that pharmacare would help to solve other problems in our health system, such as senior care (36) and drug shortages (34). Other initiatives include a Twitter campaign titled “Humans of Pharmacare,” sharing perspectives from physicians and patients about what pharmacare would mean for them (37), as well as a national survey of medical students conducted in 2019, finding that 96% want a national pharmacare program and that 92% would support amending the Canada Health Act to include prescription drugs (27).

In 2016, Jessica Harris, then a fourth-year medical student at the University of Saskatchewan and Vice-President of Government Affairs for the CFMS, appeared as a witness before the House of Commons Standing Committee on Health for their session on the development of a pharmacare program, alongside other stakeholders and experts in health policy. She presented the recommendations of the recently-adopted position paper and declared that “the CFMS strongly recommends public universal

single-payer pharmaceutical insurance that will help our future patients to access the medications they need through an evidence-based and cost-effective system" (38).

These contributions by medical students to the fight for pharmacare have no doubt played a role in moving the conversation forward, by demonstrating that the future physicians of Canada know that pharmacare is one of the most glaring gaps in our public healthcare system. However, the work is not done. Pharmacare remains one of OMSA's core advocacy priorities(39), and this position paper is OMSA's first on the topic.

GOVERNMENT RESPONSE

Pharmacare is an old idea in Canadian health policy. As far back as 1945, as part of Canada's post-war reconstruction plans, the federal government's Green Book proposals included comprehensive health and drug insurance; however, due to tax implications, these proposals were rejected by Ontario and Quebec (40). In 1962, Saskatchewan became the first province to implement universal medical coverage under Premier Tommy Douglas. This was the birth of Medicare, the first universal, single-payer, public health insurance system in North America. Unfortunately, due to cost, outpatient drugs were not included (40). Two years later in 1964, the Pearson government's Royal Commission on Health Services (the Hall Commission) recommended that outpatient prescription drugs be added to universal medical coverage. Concerned about cost, the Pearson government declined to do so (40). Subsequently, the 1997 National Forum on Health; the 2002 Commission on the Future of Health Care in Canada (the Romanow Commission); the 2002 Report of the Standing Senate Committee on Social Affairs, Science and Technology; and the 2018 report of the House of Commons Standing Committee on Health all recommended the implementation of public pharmaceutical coverage (41). After 73 years of endorsements for pharmacare from the federal government, federal commissions, and parliamentary committees, the Trudeau government created the Advisory Council on the Implementation of National Pharmacare in 2018 to prepare yet another report, and named Dr. Eric Hoskins as Chair.

The Final Report of the Advisory Council, also known as the Hoskins Report, is a seminal report outlining an executive plan for pharmacare (41). Commissioned by the federal government and published in June 2019, this landmark 184-page report recommended that the "federal, provincial and territorial governments launch national pharmacare by offering universal coverage for a list of essential medicines by January 1, 2022" (41). Despite the passing of this deadline, Canadians have yet to see the implementation of the report's advisories.

The Hoskins Report strongly urged the federal government to collaborate with provincial and territorial systems to establish a universal, public, single-payer public system. While individuals should retain the right to purchase private insurance for drugs not listed on the national formulary, pharmacare should encompass drugs based on best available evidence, with prioritization of drugs of good value and maximal health benefits (41). In order to ensure consistency in access across provinces and territories, the establishment of a Canadian drug agency for administration and coordination is imperative. Such an agency, or even potentially multiple agencies, should be governed by a board of directors that is accountable to citizens and residents of Canada. As such, this board should maintain voting members to represent patients and the public at large.

The report highlighted engagement with Indigenous communities and leaders, including First Nations, Inuit, and Métis organizations and governments. Key barriers to accessing medication for Indigenous peoples include, but are not limited to, geography of rural and remote communities, inadequate access to food and housing, systemic racism and intergenerational poverty and trauma. Ultimately, as this conversation and partnership must remain ongoing, it is crucial that any future pharmacare program enables Indigenous peoples to direct the nature of their participation (41).

Current progress includes partnerships on negotiations with drug manufacturers to secure discounts on pharmaceutical prices. An example includes the pan-Canadian Pharmaceutical Alliance (pCPA), through which provinces and territories leverage their collective buying power to negotiate lower prices for drugs covered by federal drug plans. Any new consolidated Canadian drug agency should draw

on the expertise of pCPA, in addition to the Canadian Institutes of Health Research (CIHR), the Patented Medicine Prices Review Board (PMPRB), and Health Canada (41).

In tandem with drug price negotiation, approaches to an accessible and efficient pharmacare plan should encompass a national strategy on the appropriate prescription and administration of drugs. Examples of existing educational tools for health professionals include Choosing Wisely Canada, as well as the Canadian Agency for Drugs and Technologies. Evidence has shown that clinical practice guidelines for drug prescriptions can foster substantial cost savings (42).

In summary, the recommendations of the Hoskins Reports include universal, comprehensive, accessible, portable, and public pharmacare in Canada; government collaboration on standards, funding, and implementation; Indigenous involvement in implementation and participation; the creation of a Canadian drug agency; the development of a national formulary beginning with essential medicines; a national strategy for appropriate prescription and dissemination; investment in information technology systems for secure data collection; and support with transition from private insurers to national pharmacare (41).

2022 CONFIDENCE AND SUPPLY AGREEMENT

On March 22nd, 2022, Prime Minister Justin Trudeau and NDP Leader Jagmeet Singh announced that a confidence and supply agreement had been reached between the Liberal and New Democratic parties. This meant that the NDP opposition had agreed to support the government in confidence motions in exchange for action on certain policy priorities. First in this list of priorities is healthcare reforms, including a public dental care program and pharmacare. Specifically, the government must “continu[e] progress towards a universal national pharmacare program by passing a Canada Pharmacare Act by the end of 2023 and then [task] the National Drug Agency to develop a national formulary of essential medicines and bulk purchasing plan by the end of the agreement” in June of 2025 (43).

This announcement was celebrated by many advocates for pharmacare, but with cautious optimism (44). The agreement is vague and includes no details about the proposed Canada Pharmacare Act. It is also important to note that the government had defeated a private member’s bill with the same title (“Canada Pharmacare Act”) from NDP MP Peter Julian one year prior (45). The agreement does not promise that pharmacare will be implemented by the end of the agreement. Donya Ziaee argues that the agreement “lacked in both detail and ambition,” noting that the only actual promised outcome of the agreement is drawing up a national formulary, which was already recommended by the Hoskins report in 2019 and the first phase of which was due to be launched by January of 2022 (46).

Disappointment deepened when, just a few weeks later on April 7th, the 2022 federal budget was released with no details or allocated spending for progress on pharmacare (47). The last time pharmacare was featured in a federal budget was in 2019, which proposed spending $35 million over four years, starting in 2019-20, to establish the Canada Drug Agency, and $1 billion over two years, starting in 2022-23, with up to $500 million per year on an ongoing basis to address the high cost of drugs for rare diseases. It is difficult to know how much, if any, of this spending was implemented, but as no money was allocated for these initiatives in the 2020 or 2021 budgets, it seems the government has also failed to meet these commitments.

Not three weeks after the 2022 budget was released, the government announced that it was rolling back regulations aimed to address high drug prices. These regulatory changes to the Patented Medicine Prices Review Board, the federal agency regulating prescription drug prices, were first announced in 2019 (48). They were meant to (1) require pharmaceutical companies to disclose the actual prices of drugs, (2) change the economic factors the PMPRB can consider in determining a reasonable drug price, and (3) change the list of peer countries with which the PMPRB compares prices by removing the US and Switzerland (the only two countries with prices higher than Canada’s at the time) and adding five peer countries with more moderate prices (48). These changes were supposed to be implemented in July 2020 (17), but were delayed four times after pushback from the pharmaceutical industry (48). Finally,

in April 2022, it was announced that only the third proposed change would go ahead, which will result in an estimated $2.9 billion in savings, instead of the $8.8 billion originally projected.

Despite its encouraging inclusion in the confidence and supply agreement, pharmacare is far from guaranteed. Due to its high degree of public support, it is particularly susceptible to games of "political football," whereby politicians score points and win votes by merely appearing to make progress (46). There is a long history of promises made, but not kept, and it is important that we continue to pay close attention to the action taken, or lack thereof, on this file.

PRINCIPLES

The Ontario Medical Students Association makes its recommendations using the following guiding principles:

1. That no resident of Ontario should be priced out of medically necessary treatment, whether due to being uninsured or to prohibitive copayments.
2. That coverage for pharmaceuticals should be publicly administered, comprehensive, universal, portable, and accessible, just as medical services are under the Canada Health Act.
3. That our pharmaceutical coverage should be organized to reduce overall cost to the healthcare system.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

1. That the federal government should move immediately to implement a national pharmacare program that is publicly administered, comprehensive, universal, portable and accessible, in line with the recommendations of the Hoskin Report.

Without pharmacare, medicare is incomplete. As demonstrated above, the lack of a universal public drug insurance program results in harm to patients through cost-related nonadherence. It also results in a costlier health system, with higher drug prices, administrative inefficiency, increased use of medical care and resources, and other costs. Furthermore, Canadians want pharmacare and have expressed that will again and again. The Hoskin Report recommended in 2019 that the government implement universal coverage for a list of essential medications by January 1, 2022, and Canadians are still waiting.

2. That the Ontario provincial government should actively collaborate with the federal government and advocate for the implementation of a national pharmacare program, and that it meets the standards of public administration, comprehensiveness, universality, portability and accessibility.

In the wake of the Confidence and Supply agreement, the implementation of national pharmacare is once again on the federal government's agenda. Ontario and the other provinces must work in partnership with the federal government to facilitate the development and implementation of this national program. It is crucial that the Ontario government works to ensure that the program lives up to our expectations of a national pharmacare plan and the principles of the *Canada Health Act,* and that it works in good faith to ensure its expedient implementation.

3. That, in the meantime, the Ontario government should immediately reform the Ontario public drug insurance regime to ensure comprehensive, universal, and accessible coverage.

Pharmacare is an issue of national importance, but healthcare remains a matter of provincial jurisdiction. As outlined above, Ontario already administers a patchwork of public drug plans, which, as a whole, fall short of universal, comprehensive coverage. The Ontario government has the ability to implement a public, universal pharmacare plan regardless of whether or not a federal mandate is implemented. In fact,

it would be in the provincial government's interest to begin the implementation of a program before a timeline is imposed nationally.

4. **That the Federal and Ontario provincial governments should consult with Indigenous leaders in the development of a pharmacare program, and that Indigenous communities be enabled to direct the nature of their participation in the program.**

Indigenous communities and individuals are disproportionately affected by inequitable access to medications in Ontario and Canada. As outlined above, some coverage for "federally registered/recognized members of First Nations or Inuit communities" is provided by Indigenous Services Canada. The colonial system of restricting access to "registered" members often excludes many Indigenous individuals. Further, Indigenous communities are affected by specific barriers to accessing medications, and are more likely to experience cost-related non-adherence. To ensure Indigenous communities receive the benefit of pharmacare, and to avoid additional harms, it is crucial that communities are consulted and are free to determine the nature of their participation.

5. **That OMSA expand its efforts to advocate for the implementation of pharmacare in Ontario, and collaborate with the CFMS to advocate for implementation across Canada.**

Pharmacare is one of OMSA's established advocacy priorities, but more can be done to advocate for our communities on this file. The CFMS has a strong record of advocacy going back to 2009, including innovative initiatives including polls of the membership and social media campaigns. As we await next steps under the Confidence and Supply agreement, OMSA should play an active role in holding the provincial and federal governments to account on this issue, in collaboration with our colleagues at the CFMS.

IMPLEMENTATION STRATEGY

This is OMSA's first position paper on the topic of pharmacare. It is our hope that this paper will form the foundation for more advocacy initiatives in the coming year. This paper could by expanded and adapted to serve as a backgrounder for a Provincial Day of Action, or a Federal Day of Action in collaboration with the CFMS. As new developments arise in the wake of the Confidence and Supply agreement, it is important that OMSA pay close attention and hold governments to account. This paper could provide important background information for press releases or future reports. OMSA could also consider creating a body within the advocacy portfolio, such as a committee or task force, to create new and innovative strategies to further OMSA's advocacy on this file. There are many barriers to progress on pharmacare that have proven difficult obstacles to advocacy for many years. However, OMSA can and should play a role in advocating for pharmacare on behalf of our membership.

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