Canadian Public Prescription Drug Coverage Report

According to a study conducted by Statistics Canada, “in 2021, over one in every five (21%) adults in Canada reported not having *any* [emphasis added] prescription insurance to cover medication costs” (Statistics Canada, 2022). This report explores the research question: How can public prescription drug coverage in Canada be enhanced to make prescription drugs more affordable and consistently accessible to Canadians across the country? First, I will outline the background and current state of Canada's prescription drug coverage landscape. Next, I shall describe the phenomenon of cost-related nonadherence. After, I shall outline three policy solutions addressing the research question and provide a rationale for why implementing thirteen "universal, single-payer hospital and medical care coverage program[s]," each run by a provincial or territorial government, is the most effective solution. This paper adopts the definition of universal pharmacare set out by Flood, Thomas, Moten, and Fafard where universal pharmacare is considered to be ”a system of insurance for important medicines that is progressively financed (i.e., contributions reflect users’ income) and has no access barriers due to costly copayments” (Flood et al., 2018, p.4).

“Canada is the only country in the world that has a universal healthcare system that does not have universal coverage for prescription drugs outside of hospitals” (Heart and Stroke Foundation of Canada, 2023). Approximately 7.5 million Canadians have inadequate or no prescription medication coverage (Heart and Stroke Foundation of Canada, 2023). “Canadians pay for prescription drugs through a mix of public and private plans and out-of-pocket by patients” (Al Mallees, 2023). Currently, the Canadian federal government and each province and territory have their own distinct, inconsistent, publicly funded prescription medication insurance plan (Clement & Memedovich, 2018; Government of Canada, 2020). In other words, the types of people and drugs covered, what the patients pay and what the plan pays vary significantly across jurisdictions, resulting in inconsistencies and inequity in prescription drug coverage and drug access within and across jurisdictions (Clement & Memedovich, 2018).

Moreover, Canada ranks third for the highest drug prices for brand name drugs and seventh highest for generic drugs among the Organization for Economic Cooperation and Development (OECD) countries (Health Canada, 2019). That is to say, Canadians face “some of the highest drug prices in the world” (Health Canada, 2019). Although "pharmaceutical research is producing a new generation of drugs that offer transformational benefits, particularly for sufferers of chronic conditions and rare diseases…many of these drugs" cost Canadians up to thousands of dollars per person per year (Health Canada, 2019). Within the current fragmented approach to drug coverage, Canada spends 35 percent more per capita on pharmaceuticals than the OECD average, “while millions of people are left uninsured or uninsured” (CIHI 2017, as cited in Flood et al., 2018, p. 9).

The rising costs of prescription medication in tandem, paired with insufficient prescription medication coverage, pose a critical barrier to Canadians' access to prescription drugs (Statistics Canada, 2022; Lopert et al., 2018, p.7). Those who do not qualify for public prescription medication coverage in their province or territory and who do not have private coverage through their employer may be left without drug coverage (Lopert et al., 2018, p. 7). Even those who receive benefits from their public or private drug plans may face inadequate drug coverage due to deductibles and user charges (Lopert et al., 2018, p. 7).

Cost-Related Non-Adherence (CRNA)

Those who have insufficient or no prescription drug coverage may delay, reduce, skip doses, or not fill prescriptions "because of an inability to afford medication or paying higher out-of-pocket costs" (Statistics Canada, 2022) — "a phenomenon known as cost-related non-adherence [(CRNA)]" (Law et al., 2018). In a 2021 Statistics Canada survey, those without prescription drug coverage were approximately 2.5 times more likely than their insured counterparts to not adhere to prescriptions due to cost (17% versus 7%, respectively) (Statistics Canada, 2022). These individuals also spent more out-of-pocket for prescription drugs than their insured counterparts — "27% spending $500 or more the year preceding the survey compared with 16% with insurance coverage" (Statistics Canada, 2022). Moreover, households in the lowest quintile spend four times more on out-of-pocket prescription medication expenses, as a percentage of pretax income, than those in the top quintile (Flood et al., 2018, p. 9). Therefore, individuals in households in the lowest quintile or those who are uninsured are more likely to be subject to CRNA than those in households in the top quintile or who are insured, as prescription medication use is lower in the latter group. "Among people who reported having some level of prescription insurance coverage in 2021, 70% reported having taken or been prescribed medication in the 12 months preceding the survey, compared with 56% of those without insurance coverage" (Statistics Canada, 2022).

CRNA caused by insufficient or lack of prescription drug coverage can lead to premature deaths and a reduction in the quality of life of many Canadians (Lopert et al., 2018, p. 3). It has been reported that every year, CRNA “results in up to 640 deaths among Canadians with ischemic heart disease; up to 420 deaths among working-age Canadians with diabetes, up to 70,000 Canadians (age 55+) suffering health status deterioration; and up to 12,000 Canadians (age 40+) with cardiovascular disease requiring overnight hospitalization (Lopert, Docteur and Morgan 2018 and Booth et al. 2012, as cited in Flood et al., 2018, p. 9).

Systems in Place to Address this Issue

“Currently, there is no single consistent method for individuals in Canada to obtain their medication (whether it be an inhaler or anti-depressant)” (Babayandarjazi, 2023, p. 5). For the same medication, some Canadians may pay more, some less, and some may not have access at all, highlighting a problem of inconsistent access to prescription drugs and, in turn, inequitable health outcomes across Canada (Health Canada, 2019). However, several systems and initiatives are in place to address this inconsistency in prescription medication coverage and access.

In 2010, the premiers of Canada established the pan-Canadian Pricing Alliance to consolidate buying power across the many public drug plans in Canada — re-named the pan-Canadian Pharmaceutical Alliance (pCPA) in 2015) —through the Council of the Federation’s Health Care Innovation Working Group (Council of the Federation Secretariat, n.d.; Flood et al., 2018, p.12). This organization “is tasked with negotiating lower prices for some drugs” (Flood et al., 2018, p.12). Although this approach has shown to be promising, as the organization has completed negotiations for 207 as of 2018, it has failed to serve Canadians who are uninsured or have private drug coverage as it does not negotiate prescription drug prices for these individuals (Flood et al., 2018, p.12). Furthermore, one should note that "the pCPA’s negotiations are not *binding* on participating public plans, and this inability to commit to purchasing undermines the pCPA’s negotiating power” (Flood et al., 2018, p.12). In other words, even though the pCPA can facilitate collective negotiation between the provincial and territorial drug plans and drug manufacturers, “those negotiations aren’t binding on each province or territory…[which means that] manufacturers aren’t guaranteed the entire public Canadian market [and in turn are] not likely to offer their best price [for prescription medication]” (Tatelman, 2018).

In the 2019 budget, the federal government announced three initiatives to increase the affordability and access to prescription drugs, working toward a national pharmacare program (Clement & Law, 2024, p.3). These initiatives include the following: (a) the creation of the Canadian Drug Agency (CDA), a new national drug agency that would assess the effectiveness of new prescription drugs and negotiate their prices with pharmaceutical companies on behalf of Canadians (Clement & Law, 2024, p. 3), (b) the creation of a national list of drugs to be covered (a formulary) — where $35 million was given to Health Canada to spend over four years on the CDA and the national formulary; and (c) the development of a national strategy for high-cost drugs for rare diseases — where starting in 2022, the Federal government committed to $1 billion in funding over two years, and up to $500 million a year afterwards (Clement & Law, 2024, p.7). On March 22, 2023, the federal government announced the *National Strategy for Drugs for Rare Diseases*, which included an investment of up to $1.4 billion over three years for provinces and territories through bilateral agreements "to improve access to new and emerging drugs for rare diseases and to support enhanced access to existing drugs, screening, and early diagnosis" (Jorgensen et al., 2023).

Moreover, in 2023, through a Federal-PEI bilateral agreement within the *Improving Affordable Access to Prescriptions Drugs* initiative, the federal government committed to giving Prince Edward Island $35 million over four years (2021 – 2022 to 2024-2025) “to improve access to and make prescription drugs more affordable”— another step the federal government is taking toward implementing national pharmacare (Government of Prince Edward Island, 2023). In March 2022, the Liberal Party signed a supply-and-confidence agreement with the New Democratic Party that included a commitment to pass pharmacare legislation by the end of 2023, which did not happen. However, on February 29, 2024, the federal government introduced Bill C-64,  *An Act respecting pharmacare* (Pharmacare Act), which proposes the foundational principles for first phase of national universal pharmacare in Canada and describes the Government of Canada’s intent to work with provinces and territories…to provide universal, single-payer coverage for a number of contraception and diabetes medications” (Health Canada, 2024). Moreover, this piece of legislation also outlines that the creation of the new Canadian Drug Agency — which “will be built from the existing Canadian Agency for Drugs and Technologies in health (CADTH) and in partnership with provinces and territories (Health Canada, 2023) — will “work towards the development of a national formulary, develop a national bulk purchasing strategy, and support the publication of a pan-Canadian strategy regarding the appropriate use of prescription medications” (Health Canada, 2024).

Key Considerations

There are two main key considerations that solutions addressing the problem must keep in mind. First, there is a financial consideration for initiatives aiming to increase affordability and access to prescription drugs. At a time when the Government of Canada is seeking to reduce expenditures, such initiatives will prove to be costly. Second, intergovernmental cooperation, negotiation, and jurisdiction need to be considered. Reforming publicly funded prescription drug coverage plans in Canada will likely require significant intergovernmental cooperation, negotiation, and funding by the federal government.

Overview of Policy Solutions

There are various approaches Canada can take to address the problem of consistency of public drug coverage plans and the affordability and access to prescription medication. This report will describe and critically analyze the following three policy solutions: (1) Nationally scaling the Federal-PEI bilateral agreement on Pharmacare, (2) Nationally scaling and modifying the Quebec model of prescription drug coverage, and (3) Implementing a federal single-payer universal drug plan.

Policy Solution #1: Nationally Scaling the Federal-PEI Bilateral Agreement on Pharmacare

The federal government can scale the Federal-PEI agreement on pharmacare nationally by making similar agreements with other provinces and territories (Saulnier, 2023, p. 5). So, by this solution, the federal government will provide a set amount of federal funding to address key gaps in public drug problems in their public drug plan coverage, which will target "and [be] tied to specific improvements in public-plan coverage, including expanded eligibility, increased alignment across formularies and reduced co-payments and deductibles" (Saulnier, 2023, p. 5). This solution will focus on allowing the provinces and territories to make targeted improvements, which could vary depending on the jurisdiction's most pressing needs (Saulnier, 2023, p. 5).

After a significant number of jurisdictions have accepted the federal funding offer, the federal government can collaborate with the provinces and territories to establish clear national minimum standards— which will be outlined in federal legislation— surrounding “expectations around eligibility for coverage, breadth of formulary, and out-of-pocket payments…[and] works towards cross-jurisdictional alignment” (Saulnier, 2023, p. 5). This policy solution would not affect the operations of the existing private drug plans, simply expanding the public drug plans to cover uninsured and under-insured Canadians, essentially 'filling the gap' (Saulnier, 2023, p. 4). One of the advantages of this policy solution is that it avoids a 'one-size-fits-all' solution (Saulnier, 2023, p. 5). That is to say, instead of “displacing existing public or private drug plan spending…[this approach maximizes]…the chances that provinces will engage and invest federal dollars in areas where they are most needed” (Saulnier, 2023, p. 5). Relatedly, since this approach targets uninsured and under-insured Canadians and maintains existing private prescription medication coverage, this approach will be “less disruptive and… costly to implement” (Saulnier, 2023, p. 4) relative to policy solutions that require a significant overhaul of the existing public and private prescription medications plans. Moreover, this policy solution has the potential to reduce out-of-pocket costs for many prescription drugs, improving the affordability and accessibility of prescription medication (Government of Prince Edward Island, 2023)

However, this policy solution also comes with costs and risks. This approach requires significant inter-governmental cooperation and negotiation between the federal government and the provincial and territorial governments on (a) what the national minimum standards will look like and (b) how much money each province and territory will need to make meaningful changes within their jurisdiction. Furthermore, depending on the agreed-upon national minimum standard, this policy solution can *improve* but will *only ensure* affordability and consistency in prescription drug access across the country for some Canadians. That is to say, some inequalities in drug accessibility may still exist between individuals within provinces and territories. Moreover, depending on how the federal government allocates funding to each province and territory, tension between the provinces and territories and the federal government may emerge if (a) the provinces and territories feel like they are not receiving enough funding to effectively 'fill their gaps' to reach the minimum national standard or (b) if the provinces and territories receive different levels of funding. Finally, although this policy solution will be less costly than implementing a federal single-payer universal drug plan, it does come with a considerable price tag. For example, if the federal government offered $100 per capita to provinces and territories in federal funding, the estimated total cost would be approximately $4 billion annually (Saulnier, 2023, p. 5).

Policy Solution #2: Nationally Scaling and Modifying the Quebec model of Prescription Drug Coverage

Another policy solution includes the national scaling and modification of the Quebec model of prescription drug coverage. Quebec's mixed public-private approach to universal pharmacare, which requires residents to have drug coverage either through a private plan sponsored by "their employer or professional association… or through the government-run public plan" (Health Canada, 2019) will be extended to all other provinces and territories and will “be funded through premiums similar to those for private plans of large organizations” ((Canadian Pharmacists Association, n.d., p. 6). However, one should note that within this system, “some vulnerable groups, such as low-income seniors, are exempted from paying premiums” (Health Canada, 2019). Moreover, “all private plans will offer the equivalent coverage of what is offered in the government public plan and cannot deny coverage or charge higher premiums based on age, sex, or state of health” (Casey, 2018, p. 21).

This approach has several advantages. Similar to the first policy solution, this approach achieves national universal prescription medication coverage by enhancing provincial, territorial, and federal drug plans and leveraging existing private plans and, therefore, "avoids a complete overhaul of the system, thus limiting disruption to patients' existing access to medications" (Pharmacare Working Group, 2018, p. 19). This approach "would also reduce public costs to replace coverage already offered through private plans, with which the vast majority of Canadians are currently satisfied" (Pharmacare Working Group, 2018, p. 19). Moreover, a mixed-payer system may encourage "continued drug plan innovation through regulated competition" (Pharmacare Working Group, 2018, p. 19). Finally, this approach will ensure that every Canadian has some level of drug coverage, as those who cannot afford prescription drug coverage through a private plan will be obligated to enroll in their province or territories' public drug plan (Health Canada, 2019; Canadian Pharmacists Association, n.d., p. 6). In other words, this policy solution will ensure that all Canadians have *access* to prescription medication coverage and, thus, improved access to prescription drugs.

However, this approach has various disadvantages as well. Most notably, this solution "would likely result in some level of inequity between Canadians" (Pharmacare Working Group, 2018, p. 19). Although "this can be mitigated by a comprehensive, mandatory national formulary, with supplemental coverage at additional cost" (Pharmacare Working Group, 2018, p. 19), establishing a national formulary can come with its own implementation challenges. Moreover, if cost-sharing initiatives in this approach are tied to income, this approach may be costly — "subsidies would be required for low-income Canadians to purchase supplemental private insurance" (Pharmacare Working Group, 2018, p. 19). Although this solution is expected to cost the federal government approximately $2.1 billion (Canadian Pharmacists Association, n.d., p. 6), this approach may be more costly depending on the governance and management necessary to facilitate this initiative (Pharmacare Working Group, 2018, p. 19).

Policy Solution #3: Federal-Provincial-Territorial Pharmacare Programs under National Standards

The final policy solution is the implementation of thirteen "universal, single-payer hospital and medical care coverage program[s]," each run by a provincial or territorial government "under broad national standards set through the five criteria of the *Canada Health Act* (Marchildon, 2017, p. 2). “The federal government enforces the *Canada Health Act* [*CHA*]through the contributory funding it provides to… [provincial and territorial] governments through the Canada Health Transfer. A portion of these transfers can, theoretically, be held back in situations where… [provincial or territorial] governments are in violation of the five criteria and the prohibition on physician extra-billing or facility user fees” (Marchildon, 2017, p. 2).

Similar to the way universal hospital coverage and universal medical care coverage were introduced in Canada in the 1950s and 1960s, respectively, the federal, provincial, and territorial governments will likely engage in negotiation “to determine their respective interest in such a program with all 14 governments reviewing a proposal on its basic principles, architecture, and fiscal arrangements” (Marchildon, 2017, p. 2). “If these negotiations prove successful, then the federal government could introduce a set of national standards linked to either shared-cost transfer funding or block transfers to the [provincial or territorial] governments that meet the eligibility requirements” (Marchildon, 2017, pp. 2-3).

Moreover, consistent with the original *Hospital Insurance and Diagnostic Services Act* (1957) or the *Medical Care Act*  (1966) the federal government could take one of the following three approaches to making pharmacare a reality: (1) “requiring [that] a minimum number of …[provincial or territorial] governments as a pre-condition for Pharmacare to proceed; [(2)]…requiring (or not) a formal bilateral accountability agreement between the Government of Canada and each…[provincial or territorial] government on the precise responsibilities of each government to the other…; and [(3)] establishing any potential deadlines for the…[provincial or territorial] governments to meet federal requirements to be eligible for the federal shared-cost or block transfer” (Marchildon, 2017, p. 3). Essentially, “any new *CHA*-type legislation for pharmacare should make new federal transfers contingent on provincial compliance with two critical criteria: (1) universal coverage should be provided for a basket of essential drugs, without copayments or deductibles; and (2) decisions over what to include in the basket should be made by an arm’s-length body (or bodies) that would negotiate with drug companies for the best prices” (Flood et al., 2018, p. 26).

There are various advantages to this policy solution. First, it ensures that all Canadians, under or uninsured, will have consistent coverage and access to prescription medication, eliminating "individual and regional differences in coverage and access to prescription drugs" (Casey, 2018, p. 69). Moreover, this policy solution will make prescription medication more affordable. Under this approach, an intergovernmental agency (such as the newly created CDA) will "be responsible for establishing the national drug formulary and conducting joint price negotiations [with drug manufacturers]” which will combine the purchasing power of all provincial and territorial governments and the federal government keeping prescription medication costs down (Casey, 2018, p. 66). “Lower prices [for prescription medications will] mean that governments…[ will be able to] afford to insure more people for the same price” (Flood et al., 2018, p. 9). Moreover, this approach will ensure equitable financing of prescription medications where households in the lowest quintile or individuals who are uninsured do not face greater out-of-pocket expenses for pharmaceuticals than households in the top quintile or insured individuals (Flood et al., 2018, p. 9). Moreover, the implementation of this approach is not as disruptive as some may think, as it “allows for the integration of Pharmacare into existing [provincial and territorial] Medicare systems, which is an important consideration given their existing universal coverage of inpatient drugs (Marchildon, 2017, p. 5). Also, since this policy solution is “based on an approach that is well known, at least historically, and is likely more comfortable to the majority of Canadians” (Marchildon, 2017, p. 5). Although there will be a high initial cost to implement a single-payer universal drug plan, the Parliamentary Budget Officer (PBO) estimates $1.4 billion in economy-wide savings on drug expenditures in 2024-2025 and $2.2 billion by 2027-2028 (Al Mallees, 2023; Office of the Parliamentary Budget Officer, 2023, p. 2).

Moreover, since private insurers will not be eliminated with this policy solution, they will still have a role to play. Private insurance drug plans could cover copayments and high-cost, less-efficient prescription medications that are not on the national formulary and brand names (Tatelman, 2018; Flood et al., 2018, p. 22). Furthermore, employers could "continue to provide key coverage for dental care, mental health visits and other paramedical treatments" (Tatelman, 2018). According to a 2015 survey, 85 percent of employers/plan sponsors "said they'd reallocate savings from a national pharmacare program to other health and wellness program… and 53 percent… would re-invest in other human resources programs and 24 percent would increase employees' direct compensation" (Tatelman, 2018).

However, there are several disadvantages to this approach as well. First, as noted above, there will be significant incremental costs to the public sector (provincial and federal governments combined) resulting from the transfer of expenditures currently covered by private drug plans and out-of-pocket expenditures — an estimated $11.2 billion in 2024-2025, increasing to $13.2 billion in 2027-2028 (Office of the Parliamentary Budget Officer, 2023, p. 2). Moreover, the implementation of this approach will be time-intensive. Since this approach will require provincial and territorial governments, and potentially the federal government, to shift from publicly funded drug plans — designed to help Canadians who were not covered by private drug insurance— to comprehensive, single-payer Pharmacare plans, this policy solution may take a considerable amount of time to successfully implement in whole (Marchildon, 2017, p. 3). Moreover, implementing this approach may be challenging for some provinces and may face limited cooperation and acceptance from some provinces and territories. For example, out of all the provinces and territories, the province of Quebec will likely find the shift to a single-payer system to be the most challenging as it is the only province which requires "the subsidized purchase of private (employment-based) insurance for pharmaceutical coverage rather than providing coverage directly as in other provinces and territories" (Marchildon, 2017, p. 3). In other words, Quebec's multi-payer system would have to be displaced to introduce "a single-payer…system and comply with any agreed-upon national standards" (Marchildon, 2017, p. 3).

Another disadvantage to this approach is that negotiations for a single national formulary will likely be challenging. Since federal, provincial, and territorial governments will maintain legal responsibility for their respective formularies through this approach, the only way to create a single, compulsory pan-Canadian formulary by this approach would be "through intergovernmental agreement or by [the federal government] making a national formulary a condition for eligibility (Marchildon, 2017, p. 3). If an intergovernmental agency is established by the federal, provincial and territorial government to create and maintain a single formulary for all 14 governments, then each government would have to voluntarily give up a significant amount of sovereignty and control to this agency (Marchildon, 2017, p. 4), which may be unappealing to some provinces and territories and, in turn, may limit their support of the program. If the federal government does not “make the national formulary a condition of eligibility for federal health transfers under the *Canada Health Act*," then, in theory, the provinces and territories would not have to legally adopt the formulary into their respective laws and regulations — as the agency would not have law-making authority — perpetuating the problem of inconsistent prescription medication access across Canada (Marchildon, 2017, p. 4). However, to incentivize provincial and territorial government compliance, the federal government can maintain that any province or territory that refuses to adopt the recommendations “of the intergovernmental agency could be subject to withdrawals of federal transfers” (Casey, 2018, p. 68; Marchildon, 2017, p. 4).

Each policy solution enhances the public prescription drug coverage system to some extent in Canada to make prescription drugs more affordable and consistently accessible to Canadians across the country. However, it is evident that the implementation of thirteen "universal, single-payer hospital and medical care coverage program[s]," each run by a provincial or territorial government "under broad national standards set through the five criteria of the *Canada Health Act* (Marchildon, 2017, p. 2), will promote the most cost savings for and consistent access to prescription medications across the country. While this policy solution comes with various disadvantages, additional research will need to be conducted to effectively mitigate these risks and realize the significant advantages of this approach.

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