TOWARD THE IMPLEMENTATION OF NATIONAL PHARMACARE: INTRODUCING BILL C-64

Implications for HealthCare*CAN* Members

On February 29, 2024, the federal Minister of Health, The Hon. Mark Holland introduced the first phase of universal, single-payer, national pharmacare legislation in the House of Commons. Bill C-64, *An Act respecting pharmacare,* aims to provide the groundwork towards the creation of a national formulary of essential prescription medications and the development of a bulk purchasing strategy. If passed, the legislation will also provide universal coverage for diabetes medications and contraceptives.

In this brief, HealthCare*CAN* reflects on the near decade of efforts that led to Bill C-64 being tabled in the House of Commons, and what the implications might be for members.

HIGHLIGHTS OF BILL C-64, AN ACT RESPECTING PHARMACARE

- The Minister will negotiate with provinces and territories to cover the cost of providing some diabetes and contraception medications to people for free.
- The Minister will establish a committee of experts to advise the government on how to establish universal, single-payer, national pharmacare, while respecting the jurisdictional nature of healthcare delivery in Canada.
- The new Canadian Drug Agency will be tasked with preparing a list of essential prescription drugs and related products to inform the development of a national formulary and to provide for the development a national bulk purchasing strategy for prescription drugs and related products, all in collaboration with provinces and territories, partners, and stakeholders.

BACKGROUND

THE 2015 FEDERAL ELECTION AND THE FIRST STEPS TOWARD PHARMACARE IN CANADA

The Liberal Party of Canada's 2015 federal election platform pledged to make prescription drugs more affordable to Canadians and work with the provinces and territories to lower drug prices. After the Liberals were elected to a majority government, there was great anticipation that Canada might finally implement a long overdue universal, single-payer national pharmacare program.

In 2016, the House of Commons Standing Committee on Health (HESA) agreed to undertake a study on the development of a national pharmacare program. The report, entitled *Pharmacare Now: Prescription Medicine Coverage for all Canadians*, was tabled in the House of Commons in April 2018 after that year's budget. The standing committee made many recommendations, including that Canada adopt a universal, single-payer public prescription drug coverage program. The Committee's recommendations to the government would contribute to the national dialogue on pharmacare.

THE ADVISORY COUNCIL ON THE IMPLEMENTATION NATIONAL PHARMACARE AND THE HOSKINS REPORT

In the 2018 federal budget, the federal government established *the Advisory Council on the Implementation of National Pharmacare* ("Advisory Council") and appointed Dr. Eric Hoskins, the former Ontario Minister of Health and Long-Term Care as chair. The Advisory Council was asked to provide independent advice on how best to implement national pharmacare in the manner that is affordable for Canadians and their families, employers, and governments.

The seven-member Advisory Council held roundtables, meetings, and town halls across the country in 2018-19. HealthCare*CAN* participated in a national roundtable discussion on the Implementation of National Pharmacare in Ottawa in 2018. HealthCare*CAN* was represented at the national roundtable by George Weber, former CEO of The Royal Ottawa and a former member of the HealthCare*CAN* Board of Directors. HealthCare*CAN* highlighted some of the considerations and concerns for hospitals and healthcare organizations in its brief *Towards a national pharmacare program: considerations for Canadian healthcare organizations*.

In March 2019, Dr. Eric Hoskins alongside then Minister of Health, the Hon. Ginette Petitpas Taylor and then Minister of Finance, the Hon. Bill Morneau, introduced the Interim Report of the Advisory Council on the Implementation of National Pharmacare. The Advisory Council's eight-page interim report described the foundational elements which the Council believed would ensure a successful implementation of national pharmacare. They included:

a. Create a national drug agency.

b. Develop a comprehensive national formulary.

c. Invest in drug data and information technology (IT) systems.

Several months later, in June 2019, the Advisory Council's final report was published with 60 recommendations. The Council recommended the federal government work with the provinces and territories to implement a universal, single-payer pan-Canadian public drug coverage program. The Advisory Council envisioned the creation of a Canadian drug agency, an arms-length organization to develop and administer a national formulary of medications – in place no later than January 1, 2027. The new drug agency would also perform health technology assessments, negotiate prices and supply agreements with drug manufacturers, monitor the safety and effectiveness of prescription drugs on the market, and administer a strategy to improve access to expensive drugs for rare diseases. HealthCare*CAN* analyzed the implications of the Council's recommendations in a 2019 policy brief.

Between the interim and final reports, the 2019 federal budget promised $35 million for Health Canada to establish a Canadian Drug Agency Transition Office (CDATO) to support the development of the Canadian Drug Agency as recommended in the Advisory Council's interim report. CDATO was established in 2021 to work with provinces and territories, patients, the pharmaceutical sector, and other stakeholders on scope and functions of a national drug agency.

THE LIBERAL-NDP CONFIDENCE AND SUPPLY AGREEMENT

Amid the COVID-19 pandemic, pharmacare took a backseat, although the federal government maintained its commitment to a pan-Canadian pharmacare program throughout the 2021 federal election.

Weeks before the 2022 federal budget, the Prime Minister and NDP leader Jagmeet Singh announced they had reached a supply and confidence agreement to take the minority government to the next election in 2025.

Healthcare features prominently in the deal. The deal promises tabling a Safe Long-Term Care Act, a new dental care program, and implementation of a national pharmacare program. The agreement requires the government to pass pharmacare legislation by the end of 2023 and task a national drug agency to develop a national formulary of essential medicine and a bulk purchasing plan by the end of 2025.

Fast forward to the end of 2023. Minister Holland announced that as negotiations between the two parties on pharmacare continued, they agreed that pharmacare legislation would not be introduced before 2024 but would be pushed to a date no later than March 1, 2024.

THE CANADIAN DRUG AGENCY

A few days after it was reported that pharmacare legislation would be delayed into the new year, Minister Holland announced the creation of the Canadian Drug Agency – the initial step recommended in the Hoskins report and a key piece of the supply and confidence agreement. The CDA will be built from the existing Canadian Agency for Drugs and Technologies in Health (CADTH) and in partnership with provinces and territories. The expanded mandate of CADTH will include new streams such as:

- Improving the appropriate prescribing and use of medications, for better patient health and to support system sustainability.
- Increasing pan-Canadian data collection and expanding access to drug and treatment data, including real-world evidence data, to better support patients, inform health decisions and enable robust system data analytics.
- Reducing system duplication and lack of coordination to reduce inefficiencies.

The government announced $89.5 million over five years to establish the CDA, in addition to the annual $34.2 million the federal government provides to support CADTH.

CURRENT SITUATION

Minister Holland made the Feb. 29th pharmacare announcement at an Ottawa Community Health Centre near Parliament Hill and was joined by NDP Health Critic Don Davies. Implementing pharmacare was a sticking point in upholding the supply and confidence agreement and Jagmeet Singh had been threatening for weeks to pull out of the agreement if pharmacare legislation was not introduced by the extended deadline of March 1, 2024.

Provinces and territories are being given the option to opt-in or opt-out of the plan, although the hope is that all will opt-in. Alberta and Quebec have indicated that their respective provinces will not participate but instead would like their provinces' share of the federal funding for the program to implement or enhance their own public drug coverage programs. Ontario and Saskatchewan have said they await more details before deciding. Despite the mixed reactions from provinces and territories, the new pharmacare plan has been eagerly welcomed by patient advocates, healthcare providers and others.

The *Improving Affordable Access to Prescriptions Drugs* funding partnership with Prince Edward Island was touted as a possible pharmacare model the federal government could roll out across the country in a "fill-the-gaps" approach to improve access to prescription drugs. The PEI program has expanded the comprehensiveness and affordability of PEI's multiple public drug coverage programs. Despite the successful provincial-federal partnership, this model will not be the approach the federal government will take moving forward.

The Government of Canada is taking an incremental and collaborative approach– guided by the five principles of the *Canada Health Act*, as recommended in the Hoskins report – to implement a single-payer, universal, national pharmacare program. Universal coverage for all prescription drugs is the aim, but for now the choice to cover the cost of diabetes medications[1] and contraception[2] drugs and devices will help an estimated 13 million Canadians.

Nearly four million Canadians are living with diabetes or pre-diabetes and it costs the Canadian healthcare system an estimated $30 billion a year. The government has reported that one in four Canadians with diabetes have reported not following their treatment plan due to the cost of medications and supplies, and this can lead to an increase in hospitalizations and severe complications such as stroke, blindness, and amputation. The government also announced a plan to establish a fund to support Canadians' access to supplies that diabetics require to monitor and manage their condition, such as syringes and glucose test strips. This is all in addition to the $35 million over five years the federal government pledged in Budget 2021 to help bolster its commitment to address diabetes, including its promised framework for diabetes in 2022.

Nine million Canadians of reproductive age will be eligible for free contraceptives, including intrauterine devices and emergency contraception. Last year British Columbia became the first province in Canada to provide universal free contraceptives and Manitoba announced last fall it would do the same. Taking a page from their provincial counterparts, the federal New Democrats pushed to include contraceptives in the initial list of drugs to be covered. Although considering the Liberals position on protecting women's reproductive autonomy, covering prescription contraception is a "win" for the Liberals as well. This is also a strategic move by the Liberals ahead of a challenging re-election campaign for which reproductive rights are a wedge issue between them and the Conservative Party of Canada, which currently has a large lead in the polls.

With NDP support it is expected that Bill C-64 will pass the House of Commons and Senate. Minister Holland was optimistic that should negotiations with the supportive provinces and territories start soon, drug coverage for diabetes drugs and contraceptives may be in place by the end of the year in those provinces.

After the bill becomes law, the legislation requires the Minister to establish a committee of experts to make recommendations for the operation and financing of national, universal, single-payer pharmacare. The committee is supposed to be formed 30 days after passage; the legislation also requests that the CDA work with provinces, territories, and stakeholders to:

a. Prepare a list of essential medications that would inform the development of a national formulary.
b. Inform the development of a bulk purchasing strategy.
c. Publish on the Health Canada website a pan-Canadian strategy regarding appropriate use of prescription drugs.

It is not known what the first phase of drug coverage will cost. When pressed by reporters, Minister Holland said the first phase is expected to cost $1.5 billion, but that the cost would depend on how discussions with the provinces and territories turn out. No funding is anticipated to be in the 2024 federal budget. The parliamentary budget office (PBO) estimates the cost of a single-payer, universal program would cost federal and provincial governments $11.2 billion in 2024-25, increasing to $13.4 billion in five years.

[1] List of **diabetes medications** to be discussed with provinces and territories for specific coverage (click link to view)
[2] List of **contraception** to be discussed with provinces and territories for specific coverage (click link to view)

IMPLICATIONS

Canada is the only country with a universal health insurance program that does not include comprehensive coverage for prescription drugs. Instead, its patchwork system of public and private plans or no drug coverage plan leaves some Canadians unable to afford the medications they need. A significant number of individuals and families with smaller household budgets often must choose between housing, food, medications, and other essential needs. This is particularly the case for people on a fixed income, like seniors.

To cut costs people will skip doses, delay refills, or leave prescriptions unfilled. Canadians rationing medications to save money can have very serious short- and long-term health impacts. The government's proposal to cover the cost of a few targeted drugs should help to alleviate the financial burden some Canadians face with out-of-pocket drug costs. To governments' and taxpayers' benefit, the PBO estimates cost savings on drug expenditures of $1.4 billion in 2024-25 and rising to $2.2 billion in 2027-28, if a universal, single-payer, national pharmacare plan was implemented.

Medication nonadherence can be very costly to the healthcare system as well. For example, bearing in mind the serious health impacts from diabetes and the cost of complex care, providing medications at no cost to the patient may help avoid unnecessary trips to the emergency department, reduce demand on healthcare services, and bring cost savings to the system.

But there are many pieces that must come together for this pharmacare plan to get off the ground. First and foremost, the provinces and territories must agree to get on board. Considering B.C. and Manitoba were moving to make contraceptives free, it is probably welcome news that the federal government will cover the cost. If provinces opt-out however, the federal government cannot proceed independently of the provinces. Like the bilateral health agreements, each province and territory will negotiate a pharmacare agreement. Even so, it is not unreasonable to assume provinces and territories might drag their feet on negotiating. Eight provinces and territories have signed bilateral health accords so far, with more than half signing nearly a year after the First Ministers' meeting in Ottawa in February 2023 where the health deal was announced. Likewise, in March 2023, the government agreed to provide $1.4 billion over three years to support the National Strategy for Drugs for Rare Diseases. To date, no province or territory has signed an agreement to access the funding allocated to drugs for rare diseases.[i]

Bill C-64 is an ambitious step toward implementation but there is no language or timeline in the legislation to *actually* implement a national, universal, single-payer pharmacare program. The CDA is mandated to come up with a list of essential medicines to *inform* the development of a national formulary. Should there be a change of government further work to implement national pharmacare could be dropped. Nevertheless, in any opportunity for stakeholder input, HealthCare*CAN* will be sure to emphasize hospital and healthcare organization engagement.

There are concerns that implementing a national pharmacare program could have negative consequences for Canada's health research ecosystem. The pharmaceutical industry is a valued player in the financing of health research in Canada. Canada spends far below the OECD average on research and development as a percentage of GDP. In fact, Canada is the only G7 country where research and development has steadily decreased over the last two decades. The health research sector has warned that a pharmacare program could threaten research and development funding from the pharmaceutical industry in addition to limiting Canadians access to new drugs and clinical trials.

Recommendation 60 of the Hoskins report recommends that "the federal government continue to work with universities, research hospitals and industry to sustain and grow our world class health innovation ecosystem and ensure Canada continues to contribute to the development of innovative drugs and related therapies." Making investments in health research enables the discovery of new treatments. A renewed investment in research from the federal government is needed urgently to strengthen supports for Canadian researchers conducting innovative research, ensure our country can compete globally with peers who are increasing their investments, and enable Canada to retain and attract early-career researchers, clinician-scientists, and other highly skilled workers.

In the meantime, while the pharmacare legislation makes its way through the House of Commons and Senate and we await further developments on provincial-federal negotiations, HealthCare*CAN* will continue to put the pressure on the government to make the essential investments in health research that are so deeply needed.

FOR MORE INFORMATION

HealthCare*CAN* remains attentive to our members – if your organization has any questions, concerns or feedback in connection with these developments we encourage you to contact us.

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[i] David Renwick. A year later, none of the $1.5 billion for rare disease has flowed to patients. *The Hill Times.* Feb. 28, 2024. Retrieved from: https://www.hilltimes.com/story/2024/02/28/a-year-later-none-of-the-1-5b-for-rare-disease-has-flowed-to-patients/412831/