

Prescription drugs are not covered:

Examining the impact of Canada's lack of a Pharmacare program

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Contents

Introduction	2
Theoretical Framework	8
Timeline of Pharmacare in Canada	14
1964	14
Compulsory Licensing	15
1970s	16
1990s activism regarding pharmacare and drug programs.....	17
Trillium Drug Program.....	19
1997	21
2002	21
Post Romanow writings (2003-2011).....	23
Discussion	26
Recent research and recommendation for Pharmacare (2011-present).....	26
Impact of the current system	32
Conclusion.....	40
References	43

Introduction

The cost of an appointment for receiving medical care from a doctor is, with a few exceptions, covered through provincial health care plans. Frequently the result of visiting a doctor is a prescription being written for the patient. However, in Canada the resulting prescription is not covered under provincial health care plans. Prescription drugs are only covered under provincial health care plans *if* a patient is an inpatient in a hospital (Canada Health Act, 1985 §2). In the absence of a Pharmacare program (provincial coverage for prescription drugs outside of a hospital) a recent peer reviewed article recommended that “to provide patients with long-term access to medications, physicians could lawfully admit those patients to the hospital, administer the medications, and then grant them a leave of absence from the hospital until they require a medication refill” (Wang, Lemmens, & Persaud, 2017. p. 344). The authors of the report went on to call for Canada to develop a Pharmacare program.

In 2015, a report written in the follow up to the conference Pharmacare 2020 called for Canada to establish a pharmacare program by 2020. It provides a summary of the World Health Organization requirements “[the] World Health Organization has declared that all nations are obligated to ensure equitable access to necessary medicines through pharmaceutical policies that work in conjunction with broader systems of universal health coverage” (Morgan, Martin, et al., 2015, p. 3). The program it envisioned would be cost shared, with the federal government paying 25% of costs (Morgan, Martin, et al, 2015) and would be universal with no co-insurance or deductibles from citizens (Morgan, Martin, et al., 2015).

Currently every province has set up its own provincial drug program, which is separate from provincial health care plans (Grootendorst 2002; Daw & Morgan, 2012). Canada is the only country in which coverage exists for physician visits but no similar program, like

pharmacare, exists for prescription drugs (Jacobzone, 2000). The provincial programs that do exist for prescription drugs only cover certain segments of the populations (often seniors and those on social assistance), and only cover certain drugs (see for example Ministry of Health and Long-Term Care, 2017a). Additionally, the provincial coverage process can be far from clear or simple and can vary greatly between provinces (Daw & Morgan, 2012).

In Ontario alone, there are six different programs that provide drug coverage for residents. Which program an individual is covered under, if they are covered, depends on their financial situation, age and the illness being treated. Each program has its own set of application and rules (Ministry of Health and Long-Term Care, n.d.c). Citing a study by the Canadian Life and Health Insurance Association, Kapur & Basu found that a fifty seven percent of Canadians have private insurance (mostly as a result of employment) (2005, p. 182). In Canada 36.2% of drug *spending* was by government (Canadian Institute for Health Information, 2016, p. 18).

My paper will explore the academic discussions regarding a Canadian pharmacare program, and assess the viability and access the viability and potential of programs that have been suggested by various academics and political parties. The provincial nature of current drug programs (and the fact that there is no legislation or federal mandate for similarities between provincial programs) results in a situation that *where* you live in Canada has a large impact as to *what* your drug costs will be. In 2002 Romanow highlighted that one of the problems with the current system was that “the lack of portability in prescription drug plans can be a barrier to mobility across the country” (Romanow, 2002, p. 194). This problem is an idea that appears early in the history of Canada’s medical insurance programs.

I will examine the history of the public discussion regarding Pharmacare in Canada from 1964 until the present. The major periods which will be looked at are the *Hall* commission in 1964, compulsory licensing from 1969-1993, the impact of the HIV/AIDS activists on a catastrophic drug program in Ontario in the early 1990s, the Trillium Drug Program in Ontario, the National Forum on Health in 1997, the *Romanow Report* and the *Kirby & Lebreton report* both of which were released in 2002. Finally a period of increased academic and political interest after 2011 will be discussed as well as recent changes (and proposed changes by an opposition party) to Ontario's drug programs within the discussion section.

The question remains why do differences in access to prescription drugs matter? At what point does inequity in access become an issue? Perhaps more importantly why is this paper discussing prescription drugs? Many aspects of health care are not publicly covered in Canada. If you need physiotherapy in Ontario you are only covered if you have stayed overnight in a hospital, are over 65, are on ODSP or are receiving your physiotherapy in hospital (College of Physiotherapists of Ontario, n.d.). Dental coverage is even sparser in Ontario. Those on welfare need to go to city clinics, which, if you are over 18, will only deal with emergencies (City of Ottawa, Department of Public Health, n.d.). If you are receiving ODSP, you receive a dental card that will cover root canals (in some cases), but caps are only covered for those using their mouth to control a mobility device such as a wheelchair (Ministry of Community and Social Services (Ontario) & Ontario Dental Association, 2009, p.21-24). CBC.ca recently had an opinion piece entitled "Canadians can be smug about our health care system when public coverage extends to dental care" (Chung, 2017).

However, I would argue that the next logical step for Canada to take in health care coverage would be to create a national pharmacare program. As *Pharmacare 2020* argues, a

Pharmacare program should be similar to the provincial health care programs that exist; cost shared by the provinces and federal government (Morgan, Martin, et al., 2015). It does not make sense that a person can see a doctor, but needs to pay privately to fill a prescription the doctor may write. Both are fundamental to health care. As prescriptions become a more fundamental part of medical care, and of our lives, it seems only natural that these costs become absorbed by our respective health care systems.

As early as 1964, *The royal commission on health services* (also known as the *Hall commission*) argued for prescription drug coverage (Hall, 1964). Its recommendations would have resulted in a Pharmacare program, as would have the recommendations of The National Forum on Health (1997). Later *Building on values: The future of health care in Canada—Final report* (more commonly known as *The Romanow Report*) (Romanow, 2002) and the *Report of the standing committee on social affairs, science and technology (Vol 6 recommendations for reforms* (also known as *The Kirby & Lebreton report*) (Kirby & Lebreton, 2002) both argued that Canada needed catastrophic drug coverage, with Romanow arguing we should move towards a Pharmacare system (Romanow, 2002).

As a case study I will examine the Trillium Drug Program (TDP). This Ontario program theoretically covers the cost of prescription drugs for individuals, when the cost of their prescription drugs exceeds 4% of their income (Government of Ontario, 2013). However, the program is complicated and can be difficult to understand, with the result that not everyone who *could* benefit from it *does*. Barriers to access to TDP will be examined. Under our current provincial health programs a resident knows that if they have a health card and visits a doctor, with a few exceptions, their visit will be covered. Provincial drug programs such as TDP are much more complicated and involve saving receipts, making sure you are getting limited use

codes for drugs or applying for the Exceptional Access Program (if your prescription is only covered in some circumstance) or appealing if your doctors request under the extraordinary access program (EAP) is unsuccessful (or if a drug you need is not on the EAP list) (Government of Ontario, 2013; Ministry of Health and Long-Term Care, n.d.b). The results are a program that is both poorly understood and difficult to navigate. A national Pharmacare program, administered provincially and funded partly through federal government funding has been suggested repeatedly by various academics and think tanks (Citizens' Reference Panel on Pharmacare in Canada, 2016; Gagnon, 2014; Gagnon & Hebert, 2010; Lexchin & Canadian Centre for Policy Alternatives, 2001; Morgan, Daw et al., 2013; Morgan, Law et al. 2015; Morgan, Martin et al. 2015; Hall, 1964; the National Forum on Health, 1997).

My paper is anchored in a historical institutionalist perspective. I will first introduce the relevant features of historical institutionalism, and then provide a historical institutionalist framework to understanding health care programs. The timeline of suggestions for pharmacare, and catastrophic drug care programs, will then be described starting with the with *The Hall Commission* in 1964 and ending with recent program changes which have been introduced into the ODB system to benefit those under 25 (Sousa, 2017) and a proposal by the Ontario NDP for what they calling pharmacare (Ontario New Democratic Party, 2017). The Liberal Party in its most recent budget announced coverage to those under 25, with no co-payment or co-insurance, to the coverage offered under the Ontario Drug Benefit (Sousa, 2017) while the Ontario New Democratic Party announced that, if elected, it will create a new program, which would provide coverage, free to all Ontario residents, from a list of essential drugs (Ontario New Democratic Party, 2017).

Another question I will be examining is how have the programs present in Ontario for covering prescription drugs adapted to a situation in which drugs have become an increasingly important part of medical care, increasingly expensive and where more medical care is moved outside of the hospital (where drug costs would be covered)?

Finally the discussion section of my paper will discuss the impact of Canada's not having a pharmacare program, as well as examine how successfully historical institutionalist arguments are at explaining how the situation regarding prescription drug coverage in Canada has evolved. It will also discuss how historical institutionalist explanations can explain the evolution of current situation in Canada.

Theoretical Framework

The theoretical framework anchoring my paper is historical institutionalism. According to Béland historical institutionalism “is based on the assumption that a historically constructed set of institutional constraints and feedbacks structure the behaviour of political actors and interest groups during the policy making process” (Béland, 2005, p. 29). Institutions are “the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy” (Hall & Taylor, 1996, p. 938).

With regards to Pharmacare a partial list of institutions that are involved include the provincial government, federal government, the bureaucracies associated with each as well as the provincial health care systems themselves. Added to this list would be a variety of academic and non-academic groups which are fighting for pharmacare or which oppose a Pharmacare system.

With regards to healthcare programs Tuohy has argued that “ ‘accidental logics’ ...govern the dynamics of change in the health care arena” (Tuohy, 1999, p. 250). These

forces in the broader political arena have periodically opened windows of opportunity for major policy change in the health care arena...the systems that resulted were largely... ‘accidents’ of the timing of their birth—had windows opened at different times, they might have looked quite different (Tuohy, 1999, p. 239).

I will be seeking to better understand and better explain why the ‘accidental logics’ of the Canadian health care system never opened up to a national Pharmacare system, despite the fact that they did open up to *some* type of national drug coverage in every other OECD country that has a national healthcare system (Jacobzone, 2000). As mentioned earlier, Ontario recently announced that it will be providing prescription drug coverage to those under 25 (Sousa, 2017)

and the Ontario New Democratic Party recently made announcements regarding a Ontario Pharmacare Program (Ontario New Democratic Party, 2017). Are we seeing in Ontario now an opening of an ‘accidental logic’ that will result in increased drug coverage among the population, and if so will it result in pharmacare in Ontario? If so why has the window opened?

Historical institutionalists are interested in the timing of how decisions are made and how those decisions affect later decisions. As Pierson argues:

Specific patterns of timing and sequence matter; a wide range of social outcomes may be possible; large consequences may result from relatively small or contingent events; particular courses of action, once introduced, can be almost impossible to reverse; and consequently, political development is punctuated by critical moments or junctures that shape the basic contours of social life (Pierson, 2000a, p. 251).

I will be identifying the timing and sequence of the discussions regarding the proposed development of pharmacare in Canada. I will also be examining when provincial drug coverage started (for those who were low income, and seniors), as well as when private drug insurance began to enter the market in Canada.

Along with Tuohy’s “accidental logics” many historical institutionalists emphasize timing, sequence and critical junctures (see Thelen, 1999; Thelen, 2000, Pierson 2000a, Pierson 2000b for examples). Within the literature on path-dependency Pierson argues that “once a particular path gets established... ‘critical junctures’ generate persistent paths of political development” (2000b, p. 75).

As part of examining the timing and sequence of events I will attempt to identify the moments that matter in the discussion of the development of public drug insurance between 1964 and 2017. Why didn’t any of these moments create new critical junctures, after the

beginning of cost shared medical services after the Hall Report in 1964? Clearly 1964 was a critical juncture moment for healthcare in Canada. The issue of public insurance for hospitals and physician visits clearly reached a critical juncture in Canada in the early 1960s, so why didn't coverage of prescriptions drugs reach a similar juncture at the same time?

For my paper I will be using Pierson's summary of path dependency "in which preceding steps in a particular direction induce further movement in the same direction... in an increasing returns process, the probability of further steps along the same path increases with each move down that path" (Pierson, 2000a, p.252). I will be examining whether the decisions made on prescription drug coverage show path dependence.

This theory would suggest that the choice to cover doctors and hospital care, under our system of provincial health care, partly funded by the federal government (which would be a critical juncture) has led to a situation in which path dependency and increasing returns results in a situation in which we are moving ever further from covering prescription drugs in a program such as pharmacare. Increasing returns would be experienced by the programs that already exist within our current system of shared cost healthcare, not new programs like Pharmacare.

The provinces stepped in and started providing some public drug coverage for those who were on social assistance or very low income and in some cases, that coverage predated general provincial medical coverage (Grootendorst, 2002), showing the importance of prescription drugs. The majority of provinces were providing some coverage to those who were low income by 1969 (Grootendorst, 2002, p. 87-89). *The Hall commission* identified prescription drugs, and made recommendations regarding their coverage, similar to its recommendations regarding

coverage for doctors' services, in 1964 (Hall, 1964). Programs to cover prescription drugs for seniors were added for most provinces in the 1970s (Grootendorst, 2002; Boothe, 2015, p. 43; Boothe, 2012, p. 785; Boothe, 2013 p. 424).

One aspect that I will be seeking to better understand was the impact of compulsory licensing on possible political pressure for Pharmacare. If possibilities for pharmacare would have been highest at the time when coverage for doctors' services were introduced (in the late 1960s), does the fact that compulsory licensing (and the reduced drug prices that followed) was introduced, during approximately the same time period, mean that pressure for a Pharmacare program was reduced at the same time when such a program was the most likely to be introduced in Canada?

Hacker, in looking at the development of health care programs in the US, notes that "over time...the feedback effects of those choices increasingly came to drive US health policy, as policymakers, interest groups, and the public all grappled with the enormously costly and disjointed medical complex that prior interventions...had helped create" (1998, p. 107). In addition, he notes that "since most Americans received health insurance as a fringe benefit of employment, any shift of the privately insured into the public sector would almost certainly be seen as a loss by people who had formerly enjoyed private coverage" (Hacker, 1998, p. 122). Can this observation be carried over into prescription drug coverage in Canada? The majority of Canadians have private drug insurance (according to a study by the Canadian Life and Health Insurance Association, cited by Kapur & Basu) (Kapur & Basu, 2005, p. 182).

The idea of public insurance becoming difficult to introduce after private insurance became common place could be one of the explanations to be explored as a reason for the lack of development of a Pharmacare program in Canada.

Two papers, as well as one book, have been written that deal specifically with the politics of prescription drug coverage in Canada by Boothe (2012, 2013, 2015). These papers and book provide both a history of public prescription drug coverage in Canada, as well as a historical institutionalist explanation of why pharmacare did not develop in Canada. Boothe's arguments about why pharmacare did not develop are broadly developed into two categories: with incremental programs it becomes increasingly difficult to introduce new parts of the program as time progresses (Boothe, 2012, 2015) and that "during an incremental process, policy ideas develop as actors adapt their expectations regarding a policy based on what has happened in the past, and these adaptive expectations influence their preferences and choices" (Boothe, 2013, p. 423). Most importantly Boothe argues that when an incremental approach is taken to health care policy, while it is not *impossible* to add a new health care service (such as pharmacare), it often involves the same critical juncture that starting the program initially would require (Boothe, 2015, p. 85).

I will also be looking at changes in the cost of prescription drugs in Canada. Since the end of compulsory licensing drugs are becoming increasingly expensive. The impact on individuals of not having a pharmacare program in Canada is therefore increasing. Throughout this period Canada had different rules regarding licensing of drugs. Compulsory licensing (including the importation of drugs) was introduced in 1969 lowering drug prices (Gorecki & Economic Council of Canada, 1981, p. 31). Compulsory licensing was partially stopped in 1987 and ended completely in 1993 (Lexchin, 1997, p. 90) in large part due to trade agreements,

resulting in increased prices for drugs. Trade deals are still having an impact on the price of drugs within Canada. It is estimated that the new CETA agreement will cost Canadians “between \$850 million and \$1.645 billion annually” (Lexchin & Gagnon, 2013, p. 1) in increased pharmaceutical costs.

Each province has adapted its own prescription drug coverage and due to the difficulty of covering all provincial drug programs in one paper, my paper will focus on the prescription drug coverage that is offered in Ontario under the Ontario Drug Benefit (ODB), (which covers seniors and those on social assistance) and the Trillium Drug Program (TDP), (which covers those with catastrophic drug costs).

Timeline of Pharmacare in Canada

1964

The Hall commission, in its 1964 report, clearly intended that prescription drugs be covered by the government, in a shared cost manner similar to its suggestions on physician coverage. Recognizing that “prescribed drugs are and essential and integral part of health care” (Hall, 1964, p. 641), the commission suggested that drugs be covered with a co-payment of \$1 per prescription (Hall, 1964, p. 41). In today’s dollars would amount to approximately \$7.64 per prescription (Power Purchasing Calculator, n.d.) subject to “such discount as the retailer might offer” (Hall, 1964, p. 41). Hall also recommended a Food and Drug Directorate be founded, and that a formulary be created, which would “include only those drugs which meet specifications...and therefore be eligible for inclusion” (Hall, 1964, p. 42). This would have created a Pharmacare system, similar to that which are currently in use in most OECD countries, and similar to that which was suggested by the National Forum on Health in 1997--- the main difference being that the National Forum on Health *did not* suggest a co-payment (National Forum on Health, 1997, p. 22). There is a definite continuity between suggestions that were made in 1964 for public prescription drug coverage and the suggestions that were made in 1997. While there is less continuity between Hall’s suggestions and the *Romanow report* or the *Kirby & Lebreton report* (both released in 2002), all three suggest that a national formulary be created and the *Romanow report* clearly believed that eventually a full Pharmacare program would be desirable. It appears at least that there is some path-dependency regarding arguments for a pharmacare (or catastrophic drug program) in Canada.

Compulsory Licensing

In 1969 a new law was passed amending the Patent Act, which allowed for compulsory licensing of patented prescription drugs. Under this system, an application could be made for a license for a drug that was still under patent. Generally all applications for a compulsory license were successful and involved paying a fee to the patent holder (generally 4%) (Gorecki & Economic Council of Canada, 1981, p. 1).

While an application needed to be made for a compulsory license, and the patent holder could object, in practice there was nothing that the patent holder could do to stop compulsory licensing, although they could only hold up the matter procedurally for a time. Between 1969 and 1977 Gorecki and the Economic Council of Canada found that 100% of applications for compulsory licenses were successful by 20 months' time, with 82.3% of applications being successful within 12 months (Gorecki & Economic Council of Canada, 1981, p. 41).

This system was in place between 1969 and 1987 (but lasted until 1993 for some drugs) (Lexchin, 1997). It was successful in reducing the cost of prescription drugs (Gorecki & Economic Council of Canada, 1981, p. xii). As part of the changing trade environment, the system of compulsory licensing was stopped by the Conservative government in 1987. The end of compulsory licensing did not have an impact on existing drug costs, but meant that new drugs, under patent, would not have compulsory licenses issued. This led to a gradual increase in drug costs (as new drugs were more expensive and would not have their prices reduced by compulsory licenses being issued).

Canada abolished its system of compulsory licensing completely in 1993 (Lexchin, 1997, p. 70) after limiting the use of compulsory licensing in 1987 (Lexchin, 1997, p. 70;

Shulman & Richard, 1988, p. 745). This resulted in increased drug costs. New trade deals such as CETA, in which Canada is involved, will likely also increase the cost of prescription drugs. For instance it has been estimated that new proposed rules in CETA regarding prescription drugs will cost Canadians between \$850 million and \$1.64 billion annually (Lexchin & Gagnon, 2013, p. 1).

1970s

In 1971 the federal ministry of health suggested a pharmacare program. According to Boothe “the bureaucratic authors of the proposals clearly saw them as a principled policy choice that would not only reduce drug prices, but also fill a gap in the provision of health care” (Boothe, 2013, p. 433). However the government itself was more concerned with “containing the cost of pharmaceuticals to the federal government” (Boothe, 2013, p. 433) and the proposal was shelved. Interest federally in health care issues shifted to issues other than prescription drug coverage in the 1970s.

Provincial drug programs for those who were low income or seniors started at different times, depending on the province. According to Grootendorst the earliest provincial programs to cover drug expenses started in 1946 in British Columbia. All of the provinces had some type of program for people on social assistance by 1974, with the exception of Nova Scotia, which started offering a program, to those on social assistance, by 1981. Programs for seniors who weren't on social assistance started later, with the first program for low income seniors starting in 1970, in Alberta, and all seniors having coverage in all provinces by 1980 (Grootendorst, 2002).

The increase in the provincial drug program for individuals and families on social assistance and especially for seniors is likely tied to the Canada Assistance Plan (CAP). Started in 1966, under CAP “the federal government would continue to match the funds expended by provinces under these categorical programs” (Boychuk, 1998, p.44). The program was later amended to include the cost of doctors under provincial health care programs (Boychuk, 1998, p. 43.) While funding from one cost sharing program is thought by some to bring centrality in the functioning of a program Boychuk notes that “provincial differences are deeply rooted in the economic, social, and cultural contexts of the various provinces...consequently, provincial variations are much more robust and substantial and less amenable to change through federal policy instruments” (1998, p. 42). This would explain the differences in timing of coverage for seniors under provincial prescription drug programs. The large differences that exist under provincial prescription drug programs (Daw & Morgan, 2012) could also be explained by Boychuck’s observation.

While provincial health care programs were also funded by CAP, the federal government required very specific conditions under which it would fund provincial health care programs, eventually passing the Canada Health Act (CHA) in 1985. The CHA is currently 14 pages long, and specifies that funding would be provided to programs that are under “public administration... [have] comprehensiveness [have] universality... [have] portability...and [have] accessibility” (Canada Health Act, § 7, 1985). No such law was passed regarding provincial drug programs.

1990s activism regarding pharmacare and drug programs

Compulsory licensing ended at approximately the same time as prescription medications to treat AIDS were being introduced. AIDS treatments were very expensive (by the standards

of the late 1980s and early 1990s). AIDS Action Now, a Toronto group, pushed for a drug program that would cover individuals who were not on social assistance. The group noted that among the common drug costs to individuals with HIV/AIDS would be treatments for thrush, which could cost \$295 per month and that a treatment to prevent blindness associated with HIV could cost over \$800 a month (AIDS Action Now, n.d.a, p. 4).

Some of the organizing of the HIV/AIDS activists can be seen in two letters activists group AIDS Action Now sent out to supporters before the government of Ontario introduced the Trillium Drug Program (AIDS Action Now, n.d. a; AIDS Action Now, n.d. b). In writing about the origins of the Trillium Drug Program, Walkom noted that after months of efforts to have a solution to the drug costs for those with HIV met by the government, two activists met with the Premier Bob Rae and told him that “unless the government announced a program in the interim, the Premier would be burned in effigy” (Walkom, n.d. paragraph 5). While the government had been working on a program it had been held up in delays. A program to cover catastrophic drug costs was introduced shortly after that meeting (Walkom, n.d.). The fight by AIDS activists for a drug program is credited with the adoption in Ontario in 1995 of the TDP, which helps cover the cost of catastrophic drugs.

Because of the end of compulsory licensing, drugs for treating HIV would have to live out their patent lives, until they could be offered at cheaper prices, as generics. While individual HIV drugs were slowly listed as being covered by provincial programs, the AIDS activist movement fought for a provincial drug program to cover the cost of prescription drugs for those who were working (or who had assets above what social assistance allowed) but were facing high drug costs. In 1995 the government adopted the Trillium Drug Program (Province of Ontario, n.d.).

Trillium Drug Program

The Trillium Drug Program (TDP) was officially introduced in February 1995 (Walker, 1995). A catastrophic insurance program, it covers the drug costs of an individual once they have spent a significant portion of their families income on prescription medications (about 4% of gross income) (Government of Ontario, 2013). While it has existed for over 20 years it is a program that is not generally well understood by the public and not everyone who is eligible is aware of it.

In order to qualify and make full use of the TDP the individual needs to be aware of the provincial policies as they pertain to prescription drugs. They need to make sure that the prescription drugs which they are taking are listed on the ODB formulary, that if it is a limited use drug that they have a limited use code for their prescription, and they need to keep track of what they are paying for insurance (a certain amount of the cost of insurance is covered in the provincial deductible). It is also required that the family involved keep track of the deductible and co-insurance that they are paying for their prescription drugs, or what they are paying out of pocket (if they have no insurance). They also must make an application to the TDP and prove their household income, or provide the government permission to collect information from Revenue Canada. While informative, the guide that the Ontario government provides to the Trillium Program the document is over 19 pages long, which shows how complex applying for the program can be (Government of Ontario, 2013). The guide only states that “Over-the-Counter drug products and Natural Health products, purchased without a prescription, are not eligible for TDP benefits” (Government of Ontario, 2013, p. 17) it neglects to mention that many over the counter products (such as acetaminophen) will presumably count towards the deductible (and be covered by the program) when filled as a prescription, as they *are* on the

ODB list of drugs (Ministry of Health and Long-Term Care, 2017b). An individual might also need to make sure that they had applied for coverage under the EAP program (for drugs which require special approval) or had processed an appeal prior to applying for TDP quite some time before they apply for the TDP (if they wish those drugs to be counted towards the 4% of income used by TDP) (Government of Ontario, 2013).

Unlike most private prescription drug insurance, many drugs are *only* covered if they are prescribed with special codes or in certain circumstances. The individual must be sufficiently aware to get a limited use code or to apply for the EAP with a letter from their doctor (if they drug they are taking is only covered with permission from the government in individual cases) or appeal (if the drug is not listed under drugs covered by an EAP and they feel they have a sufficient case for needing that particular drug). Limited use codes are common. A study of new drugs that were added to provincial formularies found that between 1991 and 1998 in Ontario “50% of new drugs...had their reimbursement tied to restrictive criteria listed” (Grégoire et al., 2001, p. 309). In some cases, the 4% of income deductible is covered by municipalities for those who are low income. For example the City of Ottawa states that they provide help in paying the deductible for those who cannot afford it (City of Ottawa, 2016, under subheading Trillium Drug Program).

In sum TDP can be a useful program for those who are in need of help with prescription drug costs, however it is much more complicated than the private prescription drug coverage. In many cases to take full advantage of the program would require that the individual be aware of what is necessary ahead of time (when having drugs prescribed to make sure they had the proper limited use codes, EAP coverage and appeals in place) in order to have all of the prescription, and covered non-prescription medications, they are taking which are eligible

counted towards the deductible. Individuals can also choose which month in which their deductible will start to be counted.

1997

In 1997 the National Forum on Health released its report, *Canada health action: Building on the legacy*. In the section on priorities for action it listed pharmacare as a priority as “pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs” (National Forum on Health, 1997, p.22). The Liberal platform for the 1997 noted that it “endorses pharmacare as a long-term national objective” (Liberal Party of Canada, 1997, p. 75). According to Lexchin the only other result of the suggestions by the National forum on health was a conference held on Pharmacare in Jan. 1998 (Lexchin & Canadian Centre for Policy Alternatives, 2001, p. 1). What is particularly striking about the recommendations from the National forum on health is that more than 30 years later, they mirror the recommendations made by the *Hall commission*.

2002

In 2002 two reports on health care in Canada were written. The first, *Building on values: The future of health care in Canada* (also known as the *Romanow Report*), was the result of a Royal commission on health care in Canada. Romanow referenced the recommendations of the National forum on health and stated that the eventual goal should be a Pharmacare program, but noted the significant cost that would be associated with such a program (Romanow, 2002, p. 190). Noting that there were significant disparities between access to drug costs for the individual depending on a person’s health status and on the province in which they lived, Romanow suggested that the first step towards such a program would be a federal catastrophic drug transfer. This would help the provinces pay for provincial programs to

help residents with high drug costs. He also suggested that a national drug agency be created to assess drugs, and that a national formulary be created in order to “provide consistent coverage, objective assessments, and help contain costs” (Romanow, 2002, p. 191).

While Romanow’s suggestions were less dramatic than the suggestions made by Hall in 1964, they followed the same general reasoning. Drugs were increasingly being substituted for other medical interventions. They could reduce health care costs. Yet drug insurance is not evenly spread out among the population, nor is the need for prescription drugs, and there were disparities between the coverage offered by provinces to their residents. He also suggested a national formulary to decide which drugs would be covered for cost effectiveness. While suggesting in the long run a national pharmacare program would be in the countries best interest, he suggested that a transfer to the provinces to help with setting up a catastrophic drug coverage program was a first step towards such a program (Romanow, 2002).

The health of Canadians: The federal role (the Kirby & Lebreton report) was a report of the Senate of Canada that was also published in 2002. Chapter 7 dealt with prescription drug costs (Kirby & Lebreton, 2002, p. 125-143). Kirby & Lebreton compared the situation in Canada to other countries, using a slightly different set of statistics than Romanow. However, they came to a similar conclusion as Romanow; Canada needed a catastrophic drug program. Their suggestions for a catastrophic drug program went into more detail than Romanow’s did, in suggesting how the program should function. It would have the federal government reimburse the costs to provinces for 90% of individual costs over \$5000 yearly with the remaining ten percent paid by the province or other source (*not* the individual). In order for a province to be part of this program it would need to guarantee that individuals would not pay out pocket more than \$1,500 or 3% of family income. The provinces would need to pick up the

cost of prescription drugs for individuals who were spending between \$1500 and \$5,000 yearly (Kirby & Lebreton, 2002, p. 142). They also suggested that a national formulary was needed (Kirby & Lebreton, 2002, p. 142-143).

To summarize: there were more continuities between the suggestions of the *Romanow Report*, *Kirby & Lebreton report* and the *Hall commission* than there were differences. The big difference between Romanow and Hall was that Romanow suggested that we *start* with catastrophic drug coverage and then move towards pharmacare, while the more conservative *Kirby & Lebreton report* suggested only that we move towards catastrophic drug coverage. What all three had in common was that they suggested some type of national drug program and that a national formulary of prescription drugs be created to decide which drugs would be covered.

Post Romanow writings (2003-2011)

After the *Romanow report* and *Kirby & Lebreton report*, the literature on pharmacare (and catastrophic drug coverage) focused mainly on the economics of a Canadian pharmacare system, with some of the material also focused on how a formulary could be set up.

One paper focused on the Common Drug Review (CDR) (set up in 2003). The CDR was supposed to result in more commonalities between provincial formularies for drug coverage (which mainly covers those on social assistance and seniors) in all provinces except Quebec (McMahon, Morgan, & Mitton, 2006, p. 340). The paper asked if the CDR would result in a system similar to the NICE system that was in place in Great Britain to decide on drug coverage (McMahon, Morgan, & Mitton, 2006). The CDR recommendations were not binding, thus they could recommend that a product be listed on provincial formularies, but did not make the final

decision (McMahon, Morgan, & Mitton, 2006, p. 341). The authors found that it could take the provinces quite some time to follow up on recommendations from the CDR, but that generally speaking, they followed CDR guidelines (McMahon, Morgan, & Mitton, 2006, p. 343). While they found there were similarities between the CDR and the NICE system, they also found that in Great Britain, all areas of the country are *required* to cover a drug within three months of it being approved by NICE, a situation different that was not the case in Canada (McMahon, Morgan, & Mitton, 2006, p. 345).

Morgan & Wilson examined the recommendations for catastrophic drug coverage as suggested by Romanow. Noting that it was a proposal for “*‘last dollar’* pharmacare” [emphasis mine] (Morgan & Wilson, 2004, p. 10) while those who were covered under current provincial programs received “*‘first dollar’* pharmacare” [emphasis mine] (Morgan & Wilson, 2004, p. 11,) they worried that the “provinces governments may interpret the coverage of catastrophic costs as the new pharmacare ideal and therefore reduce or eliminate existing programs that currently offer ‘first dollar’ benefits” (Morgan & Wilson, 2004, p. 11). They summarized, and further commented on Romanow’s observation that drug insurance for those with existing health problems isn’t something which traditional insurance can insure against (as it is not random and equally spread out among the population) noting that “in the area of pharmaceuticals those with the highest needs do *not* face a financial risk that is easily insured against” [emphasis in original] (Morgan & Wilson, 2004, p. 13). Citing a study from Brogan they showed that those who were “the top 5% of claimants covered by private drug insurance accounted for approximately 40% of drug costs [and that] almost two thirds...of these high drug users in 1997 were still in the top 5% of claimants in 2000” (Morgan & Wilson, 2004, p. 13).

Their interpretation was that those who were truly sick required a “subsidy” not insurance (Morgan & Wilson, 2004, p. 13) which ‘last dollar’ Pharmacare provides.

However, they also found that ‘first dollar’ coverage the provinces currently provided had benefits which would not be present in ‘last dollar’ coverage. It allowed the provinces to engage in bulk buying and increased the chance that patients take drugs as prescribed, not skipping doses drugs (thus reducing health care costs) (Morgan & Wilson, 2004, p.13-14).

They noted that

high deductibles make the public subsidy of pharmaceutical identical...across all products and product types [and that]...patients are charged with the task of weighing the pros and cons of purchasing prescribed medicines against full costs, no matter how essential the drug (Morgan and Wilson, 2004, p. 14).

Citing three studies by Soumerai & Ross-Degnan and one by Adams, Soumerai et al. and Tamblyn, Laprise et al. they noted that “patients do not always respond well to such blunt financial incentives in the pharmaceutical sector” (Morgan & Wilson, 2004, p. 14) especially as patients, in Canada, who will not bear the medical costs association with not taking a medication (Morgan & Wilson, 2004, p. 14). Financial incentives to not use medications (citing studies by Soumerai & Ross-Degnan and one by Adams, Soumerai et al. and Tamblyn) *do* reduce medication use, however patients do not necessarily choose what would be considered medically the *non-essential medications* to reduce, reducing both the use of *essential* and non-essential medications. (Morgan & Wilson, 2004, p. 14).

Discussion

Recent research and recommendation for Pharmacare (2011-present)

After it became clear that the recommendation in the Romanow Report regarding a catastrophic drug transfer would not be adopted, research on Pharmacare programs in Canada waned. However, some researchers kept researching the topic and an increasing amount of literature was published after 2011. Boothe's papers and her book still remain the only literature from political science on pharmacare (Boothe, 2012; Boothe 2013; Boothe 2015) however Gagnon and Hébert write from a public administration perspective (Gagnon & Hébert, 2010; Gagnon, 2014) with papers from economics remaining the most common (Morgan, Law, et al. 2015; Morgan, Martin, et al., 2015).

A conference, *Pharmacare 2020* was held in 2013. A report published as a result of the conference in 2015 called for a pharmacare program. It listed many reasons why pharmacare would be the best option for Canada. Citing many studies, the reasons it called for pharmacare was that all other OECD countries with a Pharmacare system pay less for their drugs than Canada do, that a formulary could be written which would ensure that Canadians were getting the best value for their treatment money, that Canada as a country could bargain more effectively for discounts on drugs than currently occurs, that pharmacare would be a business advantage to employers and that many Canadians skip essential medications because of costs (and that there would be a reduction in health care costs) and that it is unfair that those with medical problems essentially pay a tax on being ill in paying for prescriptions. In spreading out the cost of insuring Canadians for drug insurance across all Canadians we would spread the burden of insuring against illness requiring prescription drugs across all of Canadians, just like

we spread the costs of medical treatments across all of Canada. It suggested that the program be cost-shared with the federal government paying 25% of costs (Morgan, Martin, et al., 2015).

Among Canadian politics in general the issue of the cost of prescription drugs began to appear during the 2015 federal election campaign. During the election campaign, drug coverage was a topic that appeared in the NDP and Green party platforms. The NDP platform promised that the party would work with the provinces to bring in a national Pharmacare program (New Democratic Party of Canada, 2015, p. 1-2) while the Green Party of Canada promised in its platform to introduce a national Pharmacare program, as well as to provide dental coverage to those under 18 (Green Party of Canada, 2015, p. 18). The Liberal Party of Canada promised to make drugs more affordable to Canadians, through working with the provinces on bulk buying (Liberal Party of Canada, 2015, p. 9) although they did not provide further specifics of how their program would work, or include it in their costing (Liberal Party of Canada, 2015, p. 85). The Conservative Party of Canada party platform was the only major party that did not mention drug coverage within their party platform in 2015 (Conservative Party of Canada, 2015).

The Ontario New Democratic Party recently made an announcement that, if elected, it will introduce a pharmacare program, starting with 125 essential medications, and promised to add other medications to the list (Ontario New Democratic Party, 2017, p. 1) stating that “it is our objective to expand the number of essential medications available through pharmacare, until such time as a universal comprehensive national Pharmacare program has been developed and implemented” (Ontario New Democratic Party, 2017, p. 4). The Party did not identify which medications will be covered. The Party’s announcement cited a paper by Morgan et al. 2017. In examining the appendices of Morgan et al.’s 2017 article, it becomes apparent that many patients would be required to make large substitutions if they wanted to move to drugs which

would be covered by the essential medications list. For example, three anti-depressants (from two anti-depressant families) (Morgan et al., 2017, appendix), are covered vs. the 22 that are currently covered by ODB (from over 5 different drug families) (Ministry of Health and Long Term-Care, n.d. d). Women would need to choose between 4 methods of hormonal contraception (Morgan et al., 2017, appendix). It appears that the Ontario NDP plan is an *essential medications plan* as opposed to a pharmacare plan, and should be sold as such. Many Ontario residents will still find that a good deal of whatever medications they are taking are not covered and will need to be changed (if they wish to take advantage of the drugs which are covered). It appears that the Ontario NDP is either unaware, or does not care to take into account Boothe's research, which suggests that in implementing incremental programs each new step can face as many barriers as the first step (Boothe, 2015, p. 85). The Ontario NDP government introduced the TDP in 1995 (Walker, 1995). It promises it will introduce a list of 125 essential medications, which will be covered by 2020, if elected. One has to ask, given the timelines, when will a universal Pharmacare program be introduced?

This announcement of an essential medications list follows several publications on essential drug lists in Canada. The Citizens' Reference Panel on Pharmacare in Canada, (Citizens' Reference Panel on Pharmacare in Canada, 2016, p. 4), recommended that "universal, mandatory, public national drug coverage program. This system would cover prescription medications included on a formulary through public insurance...[the] report recommends an extensive but selective public formulary" (Citizens' Reference Panel on Pharmacare in Canada, 2016, p. 7). In short the report suggested a pharmacare system. However the report also suggested that

in addition to the core recommendations...the panel urged governments to act quickly to fill some of the largest gaps in prescription drug coverage in Canada. They recommend that coverage be extended to all Canadians for prescriptions of a carefully selected, minimal list of essential medications (Citizens' reference panel on pharmacare in Canada, 2016, p. 8).

Along with Morgan et al.'s 2017 paper, a recent paper by Taglione et al. has examples of how 125 medications could be chosen for an essential medication list (Taglione et al., 2017). In their paper Taglione et al. examined the medical records from patients at two medical clinics and found that, if patients were switched onto an medication *they* considered equivalent from their list---in their definition equivalent simply meant "if they treated the same condition" (Taglione et al. p. E139) (a *very* broad way of considering medications to be equivalent) and determined that "all but a fraction of individual patients who had all, all but one or all but two medications covered" (Taglione et al. p. E139). Reading the article more closely shows that "all but a fraction" meant that 72.3% of patients in an inner city clinic would have all their medications covered, while 79.8% of patients in a general clinic would have all of their drugs covered (Taglione et al. p. E141). Put another way, using their essential medications list (with their extremely broad definition of equivalent drug) would still leave over 25% of patients in the inner city clinic, and almost 20% of the patients in the general clinic, with not having all of their medications covered. Again, to put this into perspective a search of the ODB (Ministry of Health and Long-Term Care, 2017d) currently shows that it covers twenty-two anti-depressant drugs while three drugs on Taglione et al.'s list are anti-depressants. So anybody taking any one of those twenty-two medications would have been considered covered by Taglione et al. to be covered by their essential medications list. In real life while one can question if twenty two different anti-depressants need to be covered, but one can also question if *all* of the patients would be able to switch from one of the twenty two medications covered, to one of the three

medications listed especially as only two anti-depressant drug families were covered in Taglione et. al. drug list but more than five anti-depressant drug families were covered in the ODB list (Ministry of Health and Long-Term Care, 2017 d).

Morgan, Li, et al. (2017) reported on the impact of adding an essential medications list to existing prescription drug programs in the provinces. They found that their list of 117 medications would cover 44% of prescriptions written and 30% of drug expenditures in 2015 (Morgan et al., 2017, p. E295). The paper noted that there were many barriers associated with introducing a full pharmacare program into Canada and suggested “although these challenges are not insurmountable, it may be prudent to “start small” by adding universal public coverage of a carefully selected list of essential medications” (Morgan et al., 2017, p. E296). It is important to note is that included in their calculations they included a maximum \$11 co-payment for all prescriptions filled (Morgan et al., 2017, p. E297).

How the essential medication list program is developed could make a large difference in the cost to individuals *or* the cost to the government. Depending on how often the plan required prescriptions to be filled this co-payment could be a barrier. For example, if a fairly cheap medication had to be filled every month, the cost that the patient would pay (the \$11) could be *significantly* more than the cost of the drug. For cheaper prescriptions it might be cheaper to pay out pocket (and fill a larger quantity) than it would be to fill a prescription monthly. If the province does not bear any of the cost of filing a prescription, it would seem probable that provinces would require prescriptions to be filled regularly (so that they do not pay for any unnecessary drugs) *even if* this makes the cost much higher for the individual. For example a 0.10 mg dose of levothyroxine which is covered on Morgan et. al.’s essential medications list (Morgan et al., 2017, Appendix 1). It currently costs the Ontario government \$0.0382 per pill

(Ministry of Health and Long-Term Care, 2017c). Levothyroxine is taken daily (L-Thyroxine Oral, n.d.)---so a month's worth of the drug would cost about \$1.14. At the suggested fill fee of \$11 (paid by the patient), if the patient was filling the drug monthly they would bear more than 90% of the cost. A patient could fill a year's worth of this medication for \$24.93 (assuming they paid an \$11 fill fee). If they filled this prescription monthly, they could pay over \$145 a year for this medication.

The authors of this report found that Canada could reduce the costs of the drugs if it was paying for these drugs (based on the types of discounts other bulk purchasers and countries were receiving) and estimated a saving to \$3.04 Billion on the cost of their essential medications (Morgan et al. 2017).

In a similar vein the 2017 Budget in Ontario stated that

access to prescription drugs is essential for a truly responsive and sustainable health care system. Pharmacare will help ensure access to prescribed medications, particularly for those who are most in need and least able to pay. It is the natural next step in the evolution of Canada's most revered social program—universal public health care (Sousa, 2017, p. 25).

Clearly the budget recognized the importance of Pharmacare, but the actual announcement in the budget wasn't that pharmacare would be introduced, but that coverage for those under 25 to ODB would be introduced with no co-payment or deductible (Sousa, 2017, p. 25). What was not explained in the budget was why those under 25, in Ontario, would not pay and deductible or co-insurance while those over 65 (covered under ODB) would continue to face such fees, which can be extensive (Ministry of Health and Long-Term Care, n.d.a).

Impact of the current system

Kapur & Basu, citing a study by the Canadian Life and Health Insurance Association, estimate that nine percent of those with private drug insurance have a deductible of \$500 or more a year (Kapur & Basu, 2005, p. 182). In 2014 63.8% of drug costs in Canada were paid for privately (either through private insurance or through the individual paying themselves) while 36.2% of drug spending was by government (Canadian Institute for Health Information, 2016, p. 18). Gregoire, citing a paper by Jacobs and Bachynsky, Gregoire et al., found that in 2001 that “3.2 million seniors, 3.2 million people with low income and 1.5 million others relied on provincial drug benefit coverage for drug coverage” (Grégoire et al., 2001, p. 307).

Research has shown that a national pharmacare system would save Canadians money. Gagnon estimated that, depending on the type of Pharmacare program that Canadians would save between 10-42% (Gagnon & Hebert, 2010, p.11) whereas another study estimated that a Pharmacare program in Canada would save Canadians around \$7.3 billion annually (Morgan, Law et. al. 2015, p. 1). These are savings on drug costs (and insurance costs) for prescription drugs.

Prescription drugs are also becoming more costly and will become an increased burden on Canadians. An example of this would be the drugs Sovaldi and Harvony. Each of these drugs has a 95% cure rate for Hepatitis C, but come at a costly price: between \$45,000 and \$100,000 per patient (Grant, 2017, paragraph 17 and 19). Ontario and B.C. have successfully bargained for a discount on the sticker price with the company that produces the drug; however *what* they are paying isn't disclosed *and* the provinces only cover people who are in certain stages of liver disease (Grant, 2017). A recent publication on the benefits of general testing for Hepatitis C noted that provincial plans only cover treatments like Sovaldi and Harvony *after*

there has been liver damage, and added that they would not recommend general screening for Hepatitis C (outside of groups who were considered at risk) as individuals with Hepatitis C are unlikely to be able to afford treatment, and provinces won't pay for the drugs *until* these individuals have extensive liver damage. The peculiar result is that given that most patients with Hepatitis C can't afford the treatment (and the provinces prescription drug programs won't cover it for most of them) the authors therefore believed it to be more harmful to test for Hepatitis C, than to leave individuals in the dark about if they have Hepatitis C (Canadian Task Force on Preventive Health Care, 2017, p. E598). We have a communicable disease which we can treat *before* it causes much health damage to an individual. But provinces won't cover the treatment *until* it makes the individual quite ill. Because the provinces won't pay for the treatment until the individual becomes quite ill...recommendations are *against* testing for the disease. Also there is the question of how many health care dollars are used treating patients with Hepatitis C *until* the individual gets sick enough to qualify for coverage of an *effective* treatment of the disease (in other prescription drugs and in hospitalizations for Hepatitis C and its complications) when we now have an effective cure for Hepatitis C?

Similar issues arise in care for cancer patients. In *The institutionalized discrimination of cancer patients* (Taylor, 2014) Taylor argues that automatic coverage for oral cancer drugs without a co-payment should be extended to all patients in Canada. His argument largely reflects the fact that until recently all chemotherapy was provided by IV and thus administered in a hospital (and thus covered under provincial healthcare programs). Now that cancer can increasingly be treated on an out-patient basis, the medications prescribed for its treatment is proving very expensive for individuals. Individuals whom are lacking funds or private insurance (as well as the paperwork, level of income that needs to be spent to qualify for

catastrophic drug coverage in provinces such as Ontario and/or the paperwork required by private insurance) are finding barriers to receiving care and resulting stress and earlier mortality. I would question his premise that this is discrimination taken *against* those with cancer. It is just the extension of how our health care system functions to cancer patients (who previously had been shielded from this functioning as a result of their treatment being done on an in-patient basis). Cancer patients are now experiencing the same barriers to treatment (as a result of cost of medications) that every other patient might experience.

However it does fit within a historical institutionalist analysis that even if a program might be shown to save money that it may well not be adopted. If “particular courses of action, once introduced, can be almost impossible to reverse” (Pierson, 2000a, p. 251) the decision not to include prescription drug coverage in a national program, would be difficult to introduce *even if* it made financial sense or it makes sense for the health of citizens.

Since 2000 there has been a significant amount of literature on how a pharmacare system would be more affordable and better for Canadians (Gagnon & Hébert, 2010; Gagnon, 2014; Lexchin & Canadian Centre for Policy Alternatives, 2001; Morgan et al., 2013, p. 19,; Morgan, Martin, et al., 2015 to name a few publication). However this has not resulted in a Pharmacare system.

While a number of provinces (Ontario, BC, Saskatchewan, Manitoba, Newfoundland and Nova Scotia) (Daw & Morgan, 2012, p. 23) *have* adopted catastrophic drug coverage plans, there is still a wide variance in the amount of income a resident would need to spend in those provinces in order to receive coverage (which is consistent with Boychuk’s 1998 observation on provincial differences in social program). The authors found that the same family, with the

same drug costs would be required to spend from a low of \$1,704 in British Columbia to a high of \$8,746 in Nova Scotia under provincial catastrophic drug programs in order to qualify for catastrophic drug coverage (Daw & Morgan, 2012, p. 23)., and there are still co-payment or co-insurance fees which are required once the minimum has been reached (which also vary by province) (Daw & Morgan, 2012).

For those who are low income there is a refundable federal medical tax credit (which will cover costs such as prescription drugs and physiotherapy. If you earn over \$3300 in working income in a year close to 25% of your medical costs (which includes dental, drug and physiotherapy as well as other costs) will be refunded (up to a maximum of \$4,300---after a deductible of 5% of you yearly gross income is deducted). The refundable tax credit applies if you are low income (Government of Canada, 2016). Those who make enough to have taxable income can claim a tax credit for medical costs that exceed 5% of your income (up to \$4300---again minus the 5% of yearly gross income). However they will need to be aware that it can take up to 28 months to receive the refund. Most importantly, individuals need to pay upfront for the procedures/products recommended. If Canada believed that a medical tax credit was an effective way to promote health care, one would expect that it would be used for all health care. Not just for the health care services which the provinces do not cover.

The problem resides not only in the inequity of who needs drugs (some people will need drugs and not others), but in the difficulties encountered by individuals who access prescription drugs through public programs. For instance, the student plan for graduate students at University of Ottawa covers 80% of the cost of prescription drugs. In one case, a university student had to fight to get his marijuana prescription covered (the decision in that case took an 8 month appeal) (CBC News, 2016). However if you are covered by ODB (including TDP) your

doctor needs to check on a special website, or review a 204-page book, to see if your prescription is covered and if it is covered if it needs a limited use code (Ministry of Health and Long-Term Care, 2017a). If you receive the prescription *without* the appropriate limited use code, you will be unable to fill the prescription under ODB until your pharmacy can obtain the code or you can obtain a new prescription with the appropriate code. If your drug doesn't fit under the formulary there is a web page which documents other drugs, and when they will be covered under the EAP program (Ministry of Health and Long-Term Care, n.d.b). There will, however, be a delay in the processing of the paperwork, so this cannot be used for drugs that are immediately needed. If the drug you need is not covered by the EAP program, there is an appeals process for uncovered drugs, but again it requires paperwork and can take a good deal of time. Sometimes in order to meet EAP requirements you need to show that a drug *already* works (meaning the patient has to be able to acquire the prescription beforehand---despite already being on social assistance or having qualified for the TDP). For example the EAP guidelines for Atomoxetine require that it be shown that a one-month trial of the drug was a success (Ministry of Health and Long-term Care, 2016, p. 188). Given that there are multiple doses of Atomoxetine, it may take several trial doses to find a successful dose; this could mean buying several months of the drug before you could even apply for EAP coverage

Does it make sense that if you move between provinces your health care moves with you but *not* your drug coverage? While some ODB users can fill 90 days of a prescription drug others can only fill a 30-day supply. When you move between provinces it generally takes 90 days before you are covered for health care services in the new province (and your drug costs) will be considered for reimbursement in a new province (if that province has a drug program which would cover you). For the first 90 days in which you reside in a new province your

medical costs are covered by your home province. However your drug costs (if you are covered under a provincial plan) *are not*. It also leaves open the possibility, under the catastrophic drug plans, that an individual would need to pay the upfront fees *twice* in a year if they moved between provinces. If you are using a drug which requires specific permission (such as in the EAP program in Ontario) it can take quite a bit longer to get the drug covered. As Romanow noted, this is a barrier to interprovincial mobility (Romanow, 2002).

Most people do not know which drugs they can take and which they can skip. A study in Quebec looked at what occurred when user fees for prescription drugs were increased for those on welfare and senior citizens. While it found a decrease in drug usage it also found that people are not necessarily able to identify which drugs they *could* be decreasing and that there was an increase in hospital visits as a result of people decreasing the prescriptions they were taking (in order to save on copayments). What is unique about this study was that it was able to examine a group that had previously enjoyed broad coverage and then had that coverage decreased (Tamblyn et al., 2001). For those with no insurance (or on catastrophic prescription drug coverage) it has been found that they are more likely to ration prescription drug usage (Law et al. 2012) and that there could be increased health costs associated with the fact that Canada doesn't have a general pharmacare program, particularly among those who are low income.

Law et al. (2012) found that not taking prescription drugs as prescribed was linked to income, as well as to if the individual had drug coverage. Their study found, for those with insurance only 6.8% did not take prescriptions because of cost, however that number rose to 26.5% for those who had no insurance. Additionally they found that “cost-related

nonadherence was also concentrated among respondents with the lowest self-assessed health status.” (Law, et al, 2012, p. 300).

The case can also be made that Canadians are paying more for prescription drugs (overall) than they would if they had a pharmacare system. Are there possible savings to be had by having a public program, as well as inequities that could be corrected? As Gagnon & Hebert point out, private drug insurance companies charge more in administration fees than the public programs do (Gagnon & Hebert, 2010, p. 6). They examined three possible scenarios for a public drug program that would cover all of Canadians (including a plan that would pursue industrial policy similar to the plan in Quebec) and they found that in all three cases Canadians would save money overall (when taking into account the amount that is spent on private insurance). The amount saved would vary between 11.7% and 42.8% of costs depending on the type of plan which Canada decided to institute (Gagnon and Hebert, 2010, p. 9-10). Morgan et al. examined the numbers and similarly found that a Canadian pharmacare system could be expected to save between 19% and 42% of current spending on prescription drugs depending on how it was structured (Morgan, Law et al., 2015, p. 3).

Given these facts and that there has been discussion regarding pharmacare since 1964, why then do we not have a pharmacare system? Tuohy’s concept of ‘accidental logics’ in the health care system can help explain this. . The ‘accidental logic’ that created our health care system was a logic where “health care system functioned according to the logic of an accommodation between the medical profession and the state” (Tuohy, 1999, p. 203). Alternatives to our system that are less doctor focused have been suggested by Armstrong and Armstrong. They have noted that our current system of health care is “dominated by allopathic medicine” (Armstrong & Armstrong, 2010, p. 18). This is probably because our health care

system follows the path-dependency theory and increasing returns, such as that proposed by Pearson (2000a). Our system was set up in a way that was an accommodation between the state and doctors. It would likely continue to follow the same path as a result of path dependency and increasing returns would be experienced by the system as it was understood by the public (to include doctors and not include prescriptions drugs). It would also explain why our system continues to be dominated by doctors and hospitals and why getting other medical services covered have been so difficult.

Conclusion

My paper has examined the question of what efforts have been made to have pharmacare introduced in Canada. It has argued that while prescription drugs are not the only products left out of provincial health care programs, the next logical step in Canada's provincial health care programs would be to introduce a Pharmacare program.

Using historical institutionalism, I drew on key concepts in the field, including 'accidental logics' (Tuohy, 1999, p. 250), "critical junctures" (Pierson, 2000a, p. 251) and "path dependency" (Pierson 2000a, p. 252). I traced the evolution of calls for a system of provincial drug coverage that would be similar to provincial health care coverage from 1964 to the present. It also looked at some alternatives that have been suggested such as catastrophic drug program (Romanow, 2002; Kirby & Lebreton, 2002) or essential medication lists (Morgan et al 2017, Taglione et al. 2017; Ontario New Democratic Party, 2017). What it found was that all of the programs suggested include the idea of publicly funded drugs that would be provided from a formulary that would be common throughout Canada.

My paper examined catastrophic drug coverage in Ontario through a case study of the TDP. It found that the TDP had many complicated aspects that could make it difficult to access (Government of Ontario, 2013; Ministry of Health and Long-Term Care, n.d.b). It also examined two proposed essential medication lists and found that they would likely leave many Canadians with prescription taking drugs which were not covered (Morgan et al. 2017, Taglione et al. 2017) and where the patients would likely need to make substantial changes in the medications they are taking in order to be taking what has been deemed an equivalent drug by those writing the essential drug lists. It questioned whether Canadians would be able to switch to the drugs on the essential drug lists. It also brought up the issue of prescription filling fees.

If the provinces or federal government covers the cost of the drug but the consumer covers the prescription fill fee, the government could end up requiring prescriptions to be filled quite frequently which could actually make the drug more expensive to the individual than if they just filled a larger prescription at a pharmacy not using the essential drug list program.

While my paper was able to document abundant calls for Canada instituting a pharmacare program, and the fact that a pharmacare program would cost Canadians less than the current system, Canada *has not* instituted a Pharmacare program. Historical institutionalist theory, with its concepts of path dependency (Pierson, 2000a, p. 252), accidental logics (Tuohy, 1999, p. 250) and increasing returns (Pierson, 2000a, p.252)., can help to explain why pharmacare has not been introduced in Canada. Finally my paper was able to show that prescription drug costs were lowered by the introduction of compulsory licensing (in 1969) (Gorecki & Economic Council of Canada, 1981) at about the same time as provincial coverage for medical care was introduced. It is possible that this reduced pressure to create a similar critical juncture for a pharmacare program at the same time, when it might have been most likely that such a program would have been introduced. Finally I noted that Hacker has observed that in the United States it would be difficult to introduce a country wide health care system as many residents are privately insured (Hacker, 1998) and that the majority of Canadians have private health insurance (according to a study by the Canadian Life and Health Insurance Association, cited by Kapur & Basu) (Kapur & Basu, 2005, p. 182). Perhaps this is part of the explanation for why Canada has not developed a Pharmacare program.

However my paper has also shown that there has been increased interest in essential drug lists and pharmacare within academic and political circles in the last few years, both nationally, and in Ontario. Ontario is increasing its ODB program to cover those under 25

(Souza, 2017) and the Ontario NDP is calling for a pharmacare program (while introducing an essential drug lists) (Ontario New Democratic Party, 2017). Prescription drugs are becoming increasingly expensive. Few, for example, could afford the treatments that can effectively treat Hepatitis C (Canadian Task Force on Preventative Health Care, 2017; Taylor, 2014). While the increased cost of medications is not necessarily a positive feature, perhaps it will provide the impetus for Canada to create a Pharmacare system (administered by the provinces but cost shared by the federal government), especially as it has been shown that such a system would result in Canadians saving money. More than saving money it would provide insurance to all Canadians against the burden of high prescription drug costs, which it does not tend to be possible to be insured against in a regular sense (Morgan and Wilson, 2004). Canadians chose an efficient method of insuring against the cost of medical care and we have provincial coverage for medical care in every province. That medical coverage has become a national symbol. Yet we still don't insure against what is an obvious expected cost of seeing a doctor: filling a prescription. As documented in my paper there are diseases which we could treat, but which we don't test for, as the average Canadian could not afford the treatment in question (Canadian Task Force on Preventative Health Care). And we have people who are skipping medications, especially those with lower incomes, who are more affected by medication costs (Law et al. 2012). A study in Quebec found that people are not able to correctly identify which medications are essential and which are not and can be skipped (Tamblyn et al., 2001), resulting in increased health care costs. Every other OECD country which has the equivalent of medicare has some type of Pharmacare system (Jacobzone, 2000). It is well past time for Canada to develop its own Pharmacare system, for the health and well-being of its citizens.

References

- AIDS ACTION NOW! (n.d. a) “Letter from AIDS ACTION NOW! to members on Drug Reform consultation,” AIDS Activist History Project, accessed April 8, 2017, <http://aidsactivisthistory.omeka.net/items/show/189>.
- AIDS ACTION NOW! (n.d. b) “Letter re drug costs,” AIDS Activist History Project, accessed April 8th 2016, <http://aidsactivisthistory.omeka.net/items/show/189>.
- Armstrong, P., & Armstrong, H. (2010). *Wasting away: The undermining of Canadian health care* (second edition). Don Mills, Ont.: Oxford University Press. Retrieved from other editions 2003 2010
- Béland, D. (2005). Ideas, interests and institutions: Historical institutionalism revisited. In A. Lecours (Ed.), *New institutionalism: Theory and analysis* (pp. 29–50). Toronto, Ont.: University of Toronto Press.
- Boothe, K. (2012). How the pace of change affects the scope of reform: Pharmaceutical insurance in Canada, Australia and the United Kingdom. *Journal of Health Politics, Policy and Law*, 37(5), 780–800. doi:10.1215/03616878-1672718
- Boothe, K. (2013). Ideas and limits on program expansion: The failure of nationwide pharmacare in Canada since 1944. *Canadian Journal of Political Science*, 46(2), 419–453. doi:10.1017 0 S000842391300022X
- Boothe, K. (2015). *Ideas and the pace of change: National pharmacare insurance in Canada, Australia and the United Kingdom*. Toronto, Ont.: University of Toronto Press.
- Boychuk, G. W. (1998). *Patchwork of purpose: The development of provincial social assistance regimes in Canada*. Montreal & Kingston: McGill-Queen’s University Press.

Canada Health Act (consolidation). R.S.C., 1985, c. C-6, c. C-6 R.S.C. 1985. Retrieved from <http://laws-lois.justice.gc.ca/PDF/C-6.pdf>

Canadian Institute for Health Information. (2016). *National health expenditure trends, 1975 to 2016*. Ottawa, Ont.: CIHI. Retrieved Dec. 17 2016 from https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report_2016_en.pdf

Canadian Task Force on Preventive Health Care. (2017). Recommendations on hepatitis C screening for adults. *Canadian Medical Association Journal*, 189(16), E594–E604. doi:10.1503/cmaj.161521

CBC News. (2016, April 11). How a headache sufferer got insurance to pay for his medical marijuana. *CBC.ca*, Retrieved February 18, 2017, from <http://www.cbc.ca/news/canada/toronto/programs/metromorning/medical-marijuana-insurance-1.3529813>

Chung, J. (2017, June 15). Canadians can be smug about our health care system when public coverage extends to dental care: Opinion. Retrieved July 16, 2017, from <http://www.cbc.ca/news/opinion/public-dental-care-1.4160243>

Citizens' Reference Panel on Pharmacare in Canada. (2016). *Necessary medicines: Recommendations of the citizens' reference panel on pharmacare in Canada*. Vancouver, B.C.: Pharmaceutical Policy Research Collaboration, University of British Columbia. Retrieved from <https://static1.squarespace.com/static/579b7eaf2e69cf79da94700b/t/584632c515d5db6feba1d9be/1480995544677/CRPPC+-+Final+Report.pdf>

City of Ottawa. (2016, December 21). *Financial assistance*. Retrieved January 11, 2017, from <http://ottawa.ca/en/residents/older-adults/financial-assistance>

City of Ottawa, Department of Public Health. (n.d.). *Dental health | City of Ottawa*. Retrieved March 27, 2017, from <http://ottawa.ca/en/residents/public-health/healthy-living/dental-health>

College of Physiotherapists of Ontario. (n.d.). *Publicly-funded physiotherapy clinics | College of Physiotherapists of Ontario*. Retrieved March 6, 2017, from <http://www.collegept.org/PubliclyFundedPTclinics>

Conservative Party of Canada. (2015). *Protect our economy: Our Conservative plan to protect the economy*. Retrieved May 2 2017 from <http://www.conservative.ca/media/plan/conservative-platform-en.pdf>

Daw, J. R., & Morgan, S. G. (2012). Stitching the gaps in the Canadian public drug coverage patchwork? A review of provincial pharmacare policy changes from 2000 to 2010. *Health Policy*, 104(1), 19–26. doi:10.1016/j.healthpol.2011.08.015

Gagnon, M.-A. (2014). *A Roadmap to a rational pharmacare policy in Canada*. Ottawa ON and Beaconsfield PQ: Canadian Federation of Nurses and Canada Electronic Library. Retrieved from <http://celarc.ca.proxy.bib.uottawa.ca/cppc/244/244188.pdf>

Gagnon, M.-A., & Hébert, G. (2010). *The economic case for universal pharmacare: Costs and benefits of publicly funded drug coverage for all Canadians*. Montreal Que. and Ottawa ON: Canadian Centre for Policy Alternatives and Institut de recherche et d'information socio-économiques. Retrieved from <http://celarc.ca.proxy.bib.uottawa.ca/cppc/224/224883.pdf>

Gorecki, P., & Economic Council of Canada. (1981). *Regulating the price of prescription drugs in Canada: Compulsory licensing, product selection and government reimbursement programmes* (Technical Report Series No. 8). Ottawa Ont.: Economic Council of Canada.

Government of Canada, C. R. A. (2016, January 4). *Lines 330 and 331: Eligible medical expenses you can claim on your tax return*. Retrieved February 18, 2017, from <http://www.cra-arc.gc.ca/medical/>

Government of Ontario. (2013). *A guide to understanding the Trillium Drug Program*. Retrieved from [http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-S46850E-87~15/\\$File/014-S46850E-87.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-S46850E-87~15/$File/014-S46850E-87.pdf)

Grant, K. (2017, February 21). Deal reduces price of life-saving hepatitis C drugs for Canadians, *Globe and Mail*. Retrieved April 29, 2017, from <http://www.theglobeandmail.com/news/national/deal-reduces-price-of-life-saving-hepatitis-c-drugs-for-canadians/article34107225/>

Green Party of Canada. (2015). *Building a Canada that works. Together*. Retrieved May 2nd 2017 from https://www.greenparty.ca/sites/default/files/platform_english_web.pdf

Grégoire, J.-P., MacNeil, P., Skilton, K., Moisan, J., Menon, D., Jacobs, P., ... Ferguson, B. (2001). Inter-provincial variation in government drug formularies. *Canadian Journal of Public Health*, 92(4), 307–312 retrieved from <http://search.proquest.com.proxy.bib.uottawa.ca/politicalscience/docview/231990345/fulltextPDF/70C4A7D855284295PQ/6?accountid=14701>

- Grootendorst, P. (2002). Beneficiary cost sharing under Canadian provincial prescription drug benefit programs: History and assessment. *The Canadian Journal of Clinical Pharmacology*, 9(2), 79–99. Retrieved from http://www.pulsus.com/journals/pdf_frameset.jsp?jnlKy=9&atlKy=4299&isArt=t&jnlAdvert=CJCP&adverifHCTp=&sTitle=Beneficiary%20cost%20sharing%20under%20Canadian%20provincial%20prescription%20drug%20benefit%20programs%3A%20History%20and%20assessment%2C%20Pulsus%20Group%20Inc&VisitorType=
- Hacker, J. S. (1998). The historical logic of the national health insurance: Structure and sequence in the development of British, Canadian and U.S. medical policy. *American Political Development*, 12, 57–130. Retrieved from http://journals1.scholarsportal.info.proxy.bib.uottawa.ca/pdf/0898588x/v12i0001/57_thlonhbcaump.xml
- Hall, E. M. (1964). *Royal commission on health services: 1964-volume 1*. Ottawa Ont.: Roger Duhamel FRSC Queen's Printer and Controller of Stationary.
- Hall, P., & Taylor, R. C. R. (1996). Political science and the three new institutionalisms. *Political Studies*, 44(5), 936–957. doi:10.1111/j.1467-9248.1996.tb00343.x
- Jacobzone, S. (2000). Pharmaceutical policies in OECD countries: Reconciling social and industrial goals. *OECD Labour Market and Social Policy Occasional Papers*, 40. doi:10.1787/323807375536
- Kapur, V., & Basu, K. (2005). Drug coverage in Canada: Who is at risk? *Health Policy*, 71(2), 181–193. doi:10.1016/j.healthpol.2004.08.006
- Kirby, M. J., & Lebreton, M. (2002). *Report of the standing committee on social affairs, science and technology* (Vol. 6 Recommendations for Reforms). Ottawa. Retrieved from <http://www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.pdf>

Law, M. R., Cheng, L., Dhalla, I. A., Heard, D., & Morgan, S. G. (2012). The effect of cost on adherence to prescription medications in Canada. *Canadian Medical Association Journal*, 184(3), 297–302. doi:10.1503/cmaj.111270

Lexchin, J. (1997). After compulsory licensing: Coming issues in Canadian pharmaceutical policy and politics. *Health Policy*, 40(1), 69–80. doi: [10.1016/S0168-8510\(96\)00886-X](https://doi.org/10.1016/S0168-8510(96)00886-X)

Lexchin, J., & Canadian Centre for Policy Alternatives. (2001). *A national pharmacare plan: Combining efficiency and equity*. Ottawa, ON: Canadian Centre for Policy Alternatives. Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/National_Office_Pubs/pharmacare.pdf

Lexchin, J., & Gagnon, M.-A. (2013). *CETA and pharmaceuticals: Impact of the trade agreement between Europe and Canada and the cost of patented drugs* (Canadian Electronic Library 2014). Beaconsfield Que. and Ottawa: Ont.: Canadian Centre for Policy Alternatives. Retrieved from <http://celarc.ca/cppc/240/240278.pdfj>

L-Thyroxine Oral : Uses, Side Effects, Interactions, Pictures, Warnings & Dosing. (n.d.). Retrieved July 17, 2017, from <http://www.webmd.com>

Liberal Party of Canada. (1997). *Securing our future together: Preparing Canada for the 21st century*. Ottawa Ont.: Liberal Party of Canada.

Liberal Party of Canada. (2015). *A new plan for a strong middle class*. Retrieved May 2 2017 from <https://www.liberal.ca/wp-content/uploads/2015/10/New-plan-for-a-strong-middle-class.pdf>

McMahon, M., Morgan, S., & Mitton, C. (2006). The common drug review: A NICE start for Canada? *Health Policy*, 77(3), 339–351. doi: 10.1016/j.healthpol.2005.08.006

Ministry of Community and Social Services (Ontario), & Ontario Dental Association (2009). *2009 MCSS schedule of dental services and fees - mcss_dental_servicesfees.pdf*.

Retrieved from https://www.hamilton.ca/sites/default/files/media/browser/2015-02-01/mcss_dental_servicesfees.pdf

Ministry of Health and Long-Term Care-Term. (n.d.a). *Co-Payment Application for Seniors*.

Retrieved July 17, 2017 from

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-3233-87~1/\\$File/3233-87E_re.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-3233-87~1/$File/3233-87E_re.pdf)

Ministry of Health and Long-Term Care. (n.d.b). *Exceptional access program: Ontario public drug programs - Health care professionals - MOHLTC*. Retrieved February 18, 2017,

from http://www.health.gov.on.ca/en/pro/programs/drugs/eap_mn.aspx

Ministry of Health and Long-Term Care. (n.d.c). *Ontario public drug programs -Public information - MOHLTC*. Retrieved November 24, 2016, from

<http://www.health.gov.on.ca/en/public/programs/drugs/>

Ministry of Health and Long-Term Care. (2016, December). *Exceptional access program (EAP): EAP reimbursement criteria for frequently requested drugs*. Retrieved July 17, 2017, from

http://www.health.gov.on.ca/en/pro/programs/drugs/pdf/frequently_requested_drugs.pdf

Ministry of Health and Long-Term Care. (2017a). *Ontario drug benefit formulary (42nd ed.)*.

Government of Ontario. Retrieved from

http://www.health.gov.on.ca/en/pro/programs/drugs/formulary42/edition_42.pdf

Ministry of Health and Long-Term Care (2017b), *Ontario drug benefit formulary/Comparative drug index, search under acetaminophen*, Toronto: Queen's Printer of Ontario, retrieved July 17 2017 from

<https://www.formulary.health.gov.on.ca/formulary/results.xhtml?q=acetaminophen&type=1>

Ministry of Health and Long-Term Care (2017c), *Ontario drug benefit formulary/Comparative drug index, searched under thyroxine*, Toronto: Queen's Printer of Ontario, retrieved June 15 2017 from

<https://www.formulary.health.gov.on.ca/formulary/results.xhtml?q=thyroxine&type=1>

Ministry of Health and Long-Term Care (2017d). *Ontario drug benefit formulary/Comparative Drug Index, searched under all benefits 28.16.04: psychotherapeutic agents, anti-depressants*, Toronto: Queen's Printer of Ontario, retrieved May 2 2017 from <https://www.formulary.health.gov.on.ca/formulary/results.xhtml?class=281604000>

Morgan, S. G., Daw, J. R., & Law, M. R. (2013). *Rethinking pharmacare in Canada*. Toronto, ON: C.D. Howe Institute. Retrieved from

<http://celarc.ca.proxy.bib.uottawa.ca/cppc/238/238131.pdf>

Morgan, S. G., Law, M., Daw, J. R., Abraham, L., & Martin, D. (2015). Estimated cost of universal public coverage of prescription drugs in Canada. *Canadian Medical Association Journal*, 187(7), 491–497. doi:10.1503/cmaj.150281

Morgan, S. G., Li, W., Yau, B., & Persaud, N. (2017). Estimated effects of adding universal public coverage of an essential medicines list to existing public drug plans in Canada. *Canadian Medical Association Journal*, 189(8), E295–E302. doi:10.1503/cmaj.161082

- Morgan, S. G., Martin, D., Gagnon, M.-A., Mintzes, B., Daw, J. R., & Lexchin, J. (2015). *Pharmacare 2020: The future of drug coverage in Canada*. Vancouver, B.C.: Pharmaceutical Policy Research Collaboration, University of British Columbia.
Retrieved from
http://pharmacare2020.ca/assets/pdf/The_Future_of_Drug_Coverage_in_Canada.pdf
- Morgan, S. G., & Wilson, D. J. (2004). Post-Romanow pharmacare: Last-dollar first...first dollar lost? *HealthcarePapers*, 4(3), 10–20. doi:10.12927/hcpap..16871
- Ontario New Democratic Party. (2017). *Pharmacare for everyone*. Retrieved May 2 2017 from
<http://act.ontariondp.ca/sites/default/files/pharmacare-for-everyone-web.pdf>
- National Forum on Health. (1997). *Canada Health Action: Building on the legacy. The final report of the National Forum on Health* (Vol. I). Ottawa, Ont.: National Forum on Health.
- New Democratic Party of Canada. (2015). *Building the country of our dreams: Tom Mulcair's plan to bring change to Ottawa*. Retrieved April 29th 2017 from
<http://xfer.ndp.ca/2015/2015-Full-Platform-EN.pdf>
- Pierson, P. (2000a). Increasing returns, path dependence and the study of politics. *American Political Science Review*, 94(2), 251–267. doi: 10.2307/2586011
- Pierson, P. (2000b). Not just what, but when: Timing and sequence in political processes. *Studies in American Political Development*, 14(1), 72–92.
doi:10.1017/S0898588X00003011
- Province of Ontario. (n.d.). “Backgrounder on the Trillium Drug Program.”, *AIDS Activists History Project* accessed April 4, 2017, from
<http://aidsactivisthistory.omeka.net/items/show/160>

Purchasing Power Calculator, 1964 dollar retrieved Dec. 20 2016 from

<https://www.measuringworth.com/uscompare/relativevalue.php>

Romanow, R. J. (2002). *Building on values: The future of health care in Canada - Final Report*. November 28, 2002. Ottawa Ont.: Commission on the Future of Health Care In Canada.

Retrieved from <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>

Shulman, S. R., & Richard, B. W. (1988). The 1987 Canadian patent law amendments: Revised pharmaceutical compulsory licensing provisions. *Food Drug Cosm. LJ*, 43, 745-758.

Retrieved from

<http://heinonline.org.proxy.bib.uottawa.ca/HOL/Page?public=false&handle=hein.journals/foodlj43&page=745&collection=journals>

Sousa, C. (2017). *2017 Ontario budget: A stronger, healthier Ontario*. *Budget Papers*. Queen's Printer for Ontario.

Taglione, M. S., Ahmad, H., Slater, M., Aliarzadeh, B., Glazier, R. H., Laupacis, A., & Persaud, N. (2017). Development of a preliminary essential medicines list for Canada. *CMAJ Open*, 5(1), E137–E143. doi:10.9778/cmajo.20160122

Tamblyn, R., Laprise, R., Hanley, J., Abrahamowicz, M., Scott, S., Mayo, N., ... Mallet, L. (2001). Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *Journal of the American Medical Association*, 285(4), 421–429. doi:10.1001/jama.285.4.421

Taylor, D. W. (2014). *The institutionalized discrimination of cancer patients--not what Tommy Douglas intended: A business case for the universal coverage of oral cancer medicines in Ontario and Atlantic Canada*. Cambridge ON: Cameron Institute. Retrieved Jan. 9 2015 from

http://cameroninstitute.com/attachments/079_Universal%20Coverage%20of%20Oral%20Cancer%20Medicines.pdf

Thelen, K. (1999). Historical institutionalism in comparative politics. *Annual Review of Political Science*, 2(1), 369–404. doi: [10.1146/annurev.polisci.2.1.369](https://doi.org/10.1146/annurev.polisci.2.1.369)

Thelen, K. (2000). Timing and temporality in the analysis of institutional evolution and change. *Studies in American Political Development*, 14(1), 101–108.
doi:10.1017/S0898588X00213035

Tuohy, C. H. (1999). *Accidental logics: The dynamics of change in the health care arena in the United States, Britain and Canada*. New York and Oxford: Oxford University Press.

Walker, W. (1995, February 2). Groups hail plan to cut drug costs. *The Toronto Star*, p. A10.
Retrieved July 16 2017 from
<http://pqasb.pqarchiver.com/thestar/doc/437193078.html?FMT=ABS&FMTS=ABS:FT&type=current&date=Feb+2%2C+1995&author=By+William+Walker+Toronto+Star&pub=Toronto+Star&edition=&startpage=A.10&desc=Groups+hail+plan+to+cut+drug+costs>

Walkom, T. (n.d.) ““Whatever the motive, Ontario improves drug coverage”,” *AIDS Activist History Project*, accessed April 4, 2017,
<http://aidsactivisthistory.omeka.net/items/show/163>

Wang, A., Lemmens, T., & Persaud, N. (2017). Medication access via hospital admission. *Canadian Family Physician*, 63(5), 344–347.
<http://www.cfp.ca/content/cfp/63/5/344.full.pdf>

