PILLS AND BILLS

The Feasibility of Pharmacare Within Canadian Federalism

Canadians hold a great deal of pride in the fact that Canada has universal health care. Yet, Canada is the only country in the world with a universal health system that does not include prescription drug coverage, which leaves millions of citizens with zero or limited access to coverage. So, why does Canada have a glaring, pharmacare-shaped hole in its healthcare system? To address this question, a historical survey is undertaken to examine why Canada is currently lacking a system of this sort. Further, is it even feasible to implement a pharmacare program in light of Canada's constitutional and political landscape? This paper argues that intergovernmental political will at the provincial and federal levels and continued positive media coverage are key in determining this feasibility. While the implementation of such a program will not come without its challenges, the current political and social landscape suggests that with the necessary effort, such a task is possible.

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Canada is the only country in the world with a universal public health insurance system that does not include prescription drug coverage.[1] Compared to its peer countries with similar healthcare systems, Canadians are covered less often with higher costs. In fact, approximately one in ten Canadians cannot afford their prescription drugs, a statistic that swells when considering vulnerable populations, such as seniors and low-income individuals. The vulnerabilities of Canada's current disjointed landscape of pharmaceutical drug coverage run counter to the founding principles of the Canada Health Act.[2] The clear inequity of pharmaceutical drug inaccessibility and the grand implications of federal universal pharmaceutical drug coverage, referred to hereinafter as pharmacare, has led to a recent uptick in political and public interest in the field. So, why does Canada have a glaring, pharmacare-shaped hole in its healthcare system? Answering this question will be the first task of this paper through an exploration of the historical context and constitutional framework of Canadian healthcare. Ample data shows that pharmaceutical care exists as a limb of the healthcare system. Therefore, healthcare will be explored at length because there is limited federal legislation that speaks solely or primarily to pharmaceutical care. In other words, this paper will explore pharmacare with the understanding that pharmaceutical care exists under the more general healthcare umbrella.[3] Provinces will be used as the relevant regional unit of measure, despite health care deliverance disparities within provinces, as they are the best conceptualization of pharmaceutical regionalization in accordance with the constitution, the federation, and with Statistics Canada's term "health region."[4]

By understanding pharmacare within the boundaries of healthcare in the federation, this paper turns to its second task: addressing whether pharmacare is feasible in light of how Canadian institutions, politics, and the public play into the possible implementation of pharmacare.[5] The findings of this paper are that the feasibility of pharmacare is contingent on three fundamental conditions. The first is that pharmacare must be structurally feasible within the constitutional structure of federalism that denotes healthcare as a responsibility of the provinces. The second is that political will, which may spur from institutional and partisan sources, must be activated at multiple levels within the federation. Third, the public appetite for pharmacare must remain sizable, which may be in flux if significant negative media coverage threatens its inception. By pulling evidence from historical precedence of government-to-government collaboration on "big bang" policy projects and looking towards how the federation may cooperate between governments, I will exhibit that this is within reach for Canada, albeit with challenges.[6] These challenges are not only surmountable but are more in reach than other policy maneuvers of this scope and scale, which is why the subject matter at hand is pharmacare's feasibility as opposed to merely its viability. Further, this paper does not assess pharmacare's economic feasibility, although the literature agrees that pharmacare would save lives and money. Thus, I will be focusing on the feasibility of the implementation of pharmacare in the Canadian context by looking at structures, institutions, and political factors that may influence whether pharmacare is possible.

"Long Promised, Undelivered"[7]

Balkanized?: Constitutional and Historical Context[8]

It may seem surprising that universal pharmacare is not already in place, given that it has been continuously recommended, is aligned with previous health legislation, and has broad popularity. In fact, upwards of eighty percent of Canadians are in favour of the federal government establishing universal pharmaceutical drug coverage.[9] So, why has Canada not yet adopted a pharmacare system? The answer is rooted in the barriers stemming from Canadian policy institutions and electoral incentives for reform.[10] To illustrate this, I will adjust this paper's gaze backwards at the rigid jurisdictional delineations of the constitution, the historical context of Canadian health politics, and the scientific realities of the health sector.

Under section 92(7) the Constitution Act of 1867, healthcare is clearly under provincial jurisdiction, as the provinces hold the responsibility to "establish, maintain, and manage hospitals, asylums, charities and charitable institutions."[11] Historically, in the late nineteenth- and early twentieth-centuries, healthcare deliverance was largely private, deregulated, and delivered by community organizations across Canada, especially outside of large urban centers.[12] The provincial management of healthcare remained largely insular until the 1950s, when federal cost-sharing of healthcare established Canada's system of universal, comprehensive public insurance for hospital care in the 1950s.[13] This was in the form of the 1957 Hospital Insurance and Diagnostic Services Act (HIDSA), which came after numerous provinces began to implement various forms of province-wide, universal hospital plans.[14] HIDSA reimbursed half of the province's costs for specified services, which led to the national expansion of federal spending power to support and standardize healthcare.

The development and implementation of universal healthcare began to move swiftly and definitively in the 1960s and 1970s. In 1961, the federal government established the landmark Royal Commission on Health Services which offered recommendations for improvement, including health facilities and research, financing, and health services.[15] Notably, the Commission recommended coverage for prescription drugs.[16] The momentum generated by public interest in healthcare, the provincial desire for universal healthcare, and the recommendations of the Commission resulted in the Liberal Government passing the 1966 Medicare Act.[17] Medicare established a formula under which the federal government financially contributed 50 percent of provincial expenditures on insured hospital and physician services. This cemented federal funding to support healthcare for a specific set of services and given uniform terms and conditions. From 1966 to 1972, provinces worked on implementing universal medical care coverage with varying degrees of success.[18] In 1977, the previously utilized cost-sharing program was replaced with block funding to the provinces that used a combination of cash payments and tax point transfers, which allowed the federal government to reduce their tax rates while provincial governments simultaneously and proportionately raised theirs. In doing so, greater flexibility was granted to the provinces in choosing their own policy agendas and determining the prioritization of healthcare spending.[19] It is not clear why pharmacare was not initially incorporated in Medicare when it was first suggested, but a large part of those pharmaceutical costs were nowhere near what they are today, making it was a less important issue.

The 1984 Canada Health Act (CHA) was the most monumental development in Canadian healthcare as it established principles of healthcare and required that health insurance be: universal, publicly administered, portable across provinces, comprehensive of all "medically necessary" physician services and hospital care, and offered without direct charges to patients.[20] The CHA made the federal government responsible for administering national principles for the healthcare system, financial support to provinces, and several other functions, including care for Indigenous peoples on reserves. More importantly to the consideration of pharmacare is the fact that the CHA states its intention as being to facilitate reasonable access to healthcare services without barriers, including financial ones. The stated aims of the CHA were to allow for services to be provided on a prepaid basis, diminishing charges at the point-of-service. The CHA also set the criteria that provinces must fulfill in order to receive the full amount of federal cash under the Canada Health Transfer, further standardizing the quality of healthcare.[21] Moreover, the legis-

lation continues to be important to national identity, as 85 percent of citizens in 2005 felt that the elimination of this system would constitute a "fundamental change to the nature of Canada."[22]

In the 1990s, a period of federal and provincial struggle to regulate formularies and administer funding took root, as scientific breakthroughs, patent and regulation law, and the needs of the country meant that pharmaceutical policy became a pervasive issue. Pharmaceutical prices skyrocketed, with drug spending accounting for the second-largest share of healthcare costs, only behind hospitals, for the first time in history in 1997.[23] Alongside this surge in prices, the provincial regulation of pharmaceuticals became institutionalized and carried out through tools like therapeutic substitution programs, drug efficacy review boards to determine formularies, and economic analysis of drugs' cost-effectiveness.[24] Provinces composed committees to make recommendations regarding the inclusion of drugs on reimbursement formularies while attempting to assess the therapeutic significance and cost effectiveness of each drug. This is exemplified by the actions of British Columbia, which implemented a therapeutic substitution program in 1995, changing the face of provincial pharmaceutical classifications by altering how drugs were indexed and substituted for cheaper drugs. For example, Cimetidine, the approved drug for histamine-2 receptor antagonists, was substituted for the cheaper alternative Ranitidine based on the program's recommendations which may not always be bioequivalents.[25] This reference-based pricing system of approval quickly became commonplace in every province as provinces coped with cost pressures and new drug inventions. At this point, pharmacare was introduced as a policy option for dealing with this shift but was not acted upon because the costs for provinces and citizens were still manageable with transfers and insurance, which has drastically changed since the late 1990s. Moreover, provinces wanted to maintain autonomy as jurisdictional reference-based pricing systems were established. Further, the coordination of joint systems was very difficult after British Columbia had taken the plunge and there was not sufficient federal political will to mobilize the advocacy of provinces foregoing their power over pharmaceutical systems. However, these reasons for nonaction are all significantly less salient in today's political climate, as drug costs for citizens and governments continue to rise.

Sagrada Família: Evolving Policy Expectations and Contemporary Government Responses

Under the CHA, a "near-universal" system of medical coverage has evolved that is remarkably similar in scope across the nation.[26] However, a vast gap exists in the legislative foundations of pharmaceutical care, the very agent of therapeutic impact and healing for patients.[27] As I have shown thus far, the scientific realities and lack of political will to implement pharmacare stopped its exploration in the 1960s and 1990s.[28] But times are changing and medications have exploded in price, shown by the fact that Canadians spent $34 billion CAD on pharmaceuticals in 2018, which is thirteen times more than was spent in 1985.[29] Because of earlier failures to implement pharmacare, provinces deliver most of Canada's pharmaceutical services, expected to meet national standards. The Health Transfer remains the largest transfer to provinces, providing predictable long-term funding for healthcare in accordance with the principles of the Canada Health Act.[30] Provincial health insurance in each province must cover medically necessary hospital and doctors' services, although it is worth noting that medical necessity is not defined or parameterized by the CHA. Thus, 'medically necessary' services are funded by provinces, with the support of federal funds.

For low-income individuals who do not qualify for specialized insurance plans yet wish to obtain pharmaceutical healthcare, the options are to pay out-of-pocket or buy private insurance or employment-based group insurance. In 2010, publicly funded health expenditures accounted for seven of every ten dollars spent on healthcare. In 2011, it was announced that the Health Transfer will continue to grow at six percent annually until 2016-17, and starting in 2017-18, the Transfer began to grow in line with a three-year moving average of nominal Gross Domestic Product growth, with funding guaranteed to increase by at least three percent annually.[31] The current system for drug coverage in Canada is one that entails patchwork coverage, leaving millions of Canadians with zero or limited access to coverage. This has manifested in upwards of 100 government-run pharmaceutical programs in Canada and upwards of 100,000 private drug benefit plans. Thus, it seems as though the Canadian public and politicians are in agreement that the current system of pharmaceutical coverage is not ideal or efficient. This assumption will propel my work in the next section, where I will address whether pharmacare is feasible now in light of the rising costs of pharmaceuticals and a disjointed patchwork of coverage.

Paths Forward: The Feasibility of Pharmacare

Structural Feasibility: The Constitution, Legislative Viability, and Indigenous Healthcare

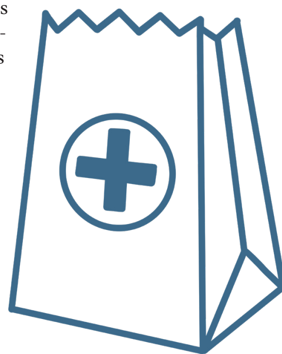
The contours of implementing pharmacare in Canada are complex and to name a single path to feasibility would be folly, as several possible paths to implementation exist. In this section, I will address whether pharmacare is feasible within the legal, constitutional, and institutional structures of Canada, ultimately concluding that it is. In order for this to happen, intergovernmental collaboration must exist between provincial governments and between levels of federation, in congruence with private sector engagement.[32] It is evident that health policy in Canada has long been coloured by the battles fought between the federal and provincial governments.[33] Due to the constitution, the federal government cannot act as the sole legislator of pharmaceutical policy, although it can heavily influence policy direction through the provision of conditional funds.[34] Thus, it would be up to the provinces to opt-into the pharmacare system, necessitating extensive intergovernmental negotiations for both the initiation and maintenance of pharmacare. The federally commissioned Advisory Council on Pharmacare suggests collective decision-making on policy, in order to achieve an equitable and uniform patient experience.[35]

A collegial approach will be useful if the council's suggestion of a Canadian Drug Agency (CDA) is to be pursued with the goal of uniformizing a federal formulary and negotiating prices with the buying power of all 37 million Canadians. Because formulary building and negotiations are currently conducted primarily on a provincial scale, difficulty may arise in the formation of a CDA due to the possible hesitancy of provinces to allow federal encroachment into formularies. Yet, this would fulfill the intention of the CHA and the principles of Medicare, thus strengthening the structural basis for pharmacare's feasibility. Although the formation of formularies and purchasing policies may present difficulties, various models of pharmacare are constitutionally and legally feasible. This is proven by the fact that every major examination of Canada's health system for the past 55 years has recommended a form of universal drug coverage, beginning with the 1964 Hall Commission Report.[36] Collaboration within the constitutional framework will need to exist within current institutional structures available for province-to-province collaboration. This entails fraternization between siloed provincial bureaucracies, communication between provincial expert panels, and federal facilitation of partisan initiatives. One of the most significant institutional infrastructures that may serve to facilitate the inception of pharmacare is the Health Ministers' Meeting, where the provincial health ministers gather to discuss and debate policy.[37]

The feasibility of effective pharmacare is complicated by Canada's settler-colonial structure, as there are unique considerations for the feasibility of administering pharmacare to Indigenous nations.

Currently, several key challenges uniquely impact Indigenous peoples while accessing prescriptions, including administrative, geographic, and systemic barriers.[38] The quality of healthcare Indigenous people experience in Canada is significantly lower than non-Indigenous people, as is well-documented in the literature and exacerbated by the fact that Indigenous healthcare is worse when it is delivered through regionalized care.[39] Regionalized healthcare––like Canada's––perpetuates federal-centric administration and control of Indigenous peoples, imposing boundaries on their territories and fragmenting community perspectives across jurisdictions.[40] While pharmaceuticals have powerful therapeutic effects, revitalizing the healthcare system's workability for Indigenous peoples will be incomplete without addressing the lack of adequate food and housing for many communities and the negative effects of colonialism on Indigenous health.[41] The federal government has suggested that there is a need to work with Indigenous peoples to develop a "process" for determining whether and how they wish to participate in national pharmacare.[42] Further, Budget 2018 dedicated 1.5 billion dollars to Indigenous healthcare. These considerations, however, do not spell out any of the actual details of Indigenous participation in national pharmacare, only that there are significant structural barriers. Financial and physical barriers to obtaining prescriptions are far more prevalent for Indigenous people, which will need to be structurally addressed by pharmacare if Canada hopes to truly adhere to the CHA.[43] Thus, in order to successfully and consensually implement pharmacare, it is clear that substantive consultations will need to be undertaken that are written into the formation of pharmacare.

Due to a lack of policy precedent, clear legislation, and the suboptimal pharmaceutical coverage for Indigenous peoples, it is difficult to analyze the feasibility of delivering a pharmacare system in this context.[44] It is important to note that only registered First Nations and Inuit qualify for non-insured benefits at present. The federal government has stated that it is willing to act in accordance with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which states that "Indigenous peoples have the right to be actively involved in developing and determining health... programmes affecting them" and to "administer such programmes through their own institutions."[45] However, this commitment inspires little confidence, as the federal government has consistently engaged with Indigenous nations and people through conduct in non-compliance with UNDRIP.[46] Further, there is significant evidence that the provinces of Canada do not adequately advocate for Indigenous health issues or provide sufficient healthcare for Indigenous communities.[47] Therefore, in order for pharmacare to be realized, provincial governments will need to engage in dialogue and deliberation on many levels of authority, including with Indigenous peoples, and must be willing to concede partial autonomy in exchange for fiscal transfers. Pharmacare's implementation has important implications, as the federal government would likely have a heavy hand in guiding policy areas that fall under section 92(7) of the constitution. This remains feasible, as there is historical precedent for similar exchanges of power for funds in healthcare, exhibited by Medicare. The conditions for this exchange will need to be conducted through political parties, bureaucracies, and institutional meetings.



As aforementioned, it is unclear what the role of Indigenous peoples will be in the formation of this policy due to section 91(24) of the constitution, although it has been the historical norm that consultations will tend towards being symbolic rather than substantive. Thus, pharmacare's implementation within provinces and Indigenous communities will depend highly on whether provinces opt in and how ethically the federal government can engage in nation-to-nation policymaking. The limitations to my argument that pharmacare is structurally and politically feasible are mostly related to Canada's slow, incremental health policy development system and its colonial structure. This creates significant barriers to implementation for early proposals of pharmacare which can be attributed to the bureaucracy of Canada's institutions, electoral incentives, and policymaking in liberal democracies.[48] Despite the barriers presented by this policy incrementalism, pharmacare remains a feasible opportunity for collaborative policymaking due to the room allowed by the constitutional and structural room for policy collegialism.

Feasibility Based on Political Will

At a 2015 meeting of the provincial and territorial health ministers, there was concern over whether pharmacare is "politically feasible."[49] This section will analyze that claim by examining whether political will may activate within the structure of Canadian politics, thereby on multiple levels of the federation and transcendent of party, to facilitate pharmacare. In terms of multi-layer will, it is clear that political will must exist amongst provincial and federal governments, thus this paper must demonstrate that this will has the potential to spur from both levels.

Turning first to the federal level, it is clear that the will to implement pharmacare is gaining traction, as the Liberals, the Greens, and the New Democrats all included pharmacare in their 2019 election platforms.[50] The parties cited the substantive medical and pharmacoeconomic advantages, pointing to key inefficiencies within the current system, which are largely due to Canada missing out on the collective bargaining power of our population.[51] Yet, this massive spending on the federal level does not take the onus off of private citizens nor off of provinces. This has notable economic implications, as Canada could save an average of seven billion dollars per year on drug costs if pharmacare is implemented.[52] Further, long-term costs would decrease, as patient adherence to preventive medicine drastically reduces the need for emergency interventions, namely in the form of costly procedures.[53] Moreover, if all provinces increased per capita drug spending to the levels observed in the two provinces with the highest spending level, an average of 584 fewer infant deaths per year and over 6 months of increased life expectancy would occur.[54]

Unlike the other three major federal parties, the Conservative Party is staunchly opposed to introducing pharmacare, citing that approximately 95 percent of Canadians are already *eligible* for drug coverage either through employers or provinces.[55] This number is deceiving, as the actual number of Canadians who do not actually *have* coverage is closer to twenty percent. However, former leader Andrew Scheer stated in 2019 that the Conservatives are willing to work towards "filling gaps" in coverage, although he has not specified how.[56] Thus, if pharmacare were delayed until 2023 and the Conservatives formed the next Canadian government, it would clearly be unfeasible. Short of this delay, political will clearly exists at the federal level to establish pharmacare.

This is not enough, though, as the provinces need to be active participants in creating national healthcare policy. As stated by Liberal Prime Minister Justin Trudeau, federal actors are unwilling to stick their neck out for pharmacare if it is not reflected in party behaviour at the provincial level. This is exhibited by Trudeau's 2019 statement that he does not want to "send money to [Premier of Ontario] Doug Ford or [Premier of Alberta] Jason Kenney... if they are not going to actually move in the right direction."[57] Provincial political will

comes institutionally from the voters due to Canada's electoral system, which means that provincial governments act as mouthpieces for policy expectations within the federation. Thus, provincial will to institute a pharmacare system must come from the provincial governments, and by extension from voters who theoretically dictate their policy priorities via voting behaviour.

Canada's current high spending on drugs, especially in comparison to their OECD peers, does not shield citizens or provinces from paying for pharmaceuticals. Citizens are often still on the hook for copayments and/or deductibles to ensure pharmaceutical coverage. This is a detriment to pharmaceutical accessibility, as even small co-payments may result in thousands of Canadians skipping on filling their prescriptions. In congruence with this, provincial governments end up paying a significant portion of the costs incurred, because they have no jurisdiction over market competitiveness or pricing. Because of these facts, it is conceivable that provinces see the advantages of developing a pharmacare system, strengthened by the trend that provincial units are inching towards negotiating a pharmacare system, exhibited by the generative discussions occurring between provinces. However, the election of provincial parties that convey platforms that are antithetical to pharmacare could present an insurmountable challenge to its inception, as these parties would institutionalize perspectives that prioritize provincial autonomy. Because of the constitution, the existence of pharmacare is locked in a state of political immobility if activation does not transcend provincial considerations.[58] Thus, to prove that pharmacare is politically feasible, there must be benefits associated with implementing national pharmacare that cut across provincial considerations. Provincial actors would likely be inhibitive to pharmacare's feasibility if there was evidence that private pharmaceutical interests agglomerate only in specific provinces, as insurance firms and the pharmaceutical industries would be the major "losers" of this program.[59] Yet, due to the nature of these industries, it is unlikely that significant economic or political considerations will become politically activated *only* in certain regions in order to prevent these industries from losing profit, because the industry is consistently pervasive in all the major regions of Canada. This does not erase the intergovernmental difficulties remaining in the coordination of a policy plan of this size, shown by Trudeau's consistent avoidance of providing details about facilitating intergovernmental cooperation while campaigning on pharmacare.[60] However, this does suggest that pharmacare will be able to garner provincial and federal political will to become a tangible policy plan.

Pharmacare is most feasible in considerations of political will when the implications of not allowing federal influence into one's healthcare would mean negative effects for one's province. In regard to pharmacare, these negative effects are the aforementioned issues with accessing pharmaceuticals that lead to prescription rationing, missed prescriptions, and economic burden on citizens. This leads to more expensive health outcomes long-term, as effective use of pharmaceuticals is the primary way to prevent more costly medical interventions, like surgery. Dr. Eric Hoskins, the chair of Canada's Advisory Council on the Implementation of Pharmacare, spoke to the validity of this logic, pointing out that: "It makes no sense to have people end up in a hospital bed that costs $1,000 a day because they can't afford a pill."[61] It is clear that the political will from the provinces to yield autonomy in favour of better outcomes was exhibited with HIDSA and with other health improvement policy like the 2007 *Patient Wait Times Guarantee*, both of which allowed the federal government to encroach further into section 92(7) territory for the sake of health economics and improved patient outcomes. Therefore, as long as there is sufficient political will stemming from the provincial level to implement pharmacare despite a potential loss of power and/or autonomy, provinces will work to implement pharmacare. The Premiers of the provinces generally point to the fact that many provinces already have plans, but that they are willing to move forward if Ottawa leads the talks, exhibiting a measured stance but also an openness to responding to the will of the electorate and the federal government.[62] This provincial will must exist in congruence with federal will to claim that pharmacare is feasible due to the federal nature of Canada, which I have explored and expanded on by showing that will does exist.

Media Coverage and Public Opinion

A paramount consideration to undertake is whether political will to implement pharmacare exists at the social and public levels of how information is disseminated to Canadian citizens, who elect leaders in provincial and federal elections. In this sense, political will is available to be readily activated and articulated by institutions, based on polling data that states that Canadians support its inception.[63] In other words, Canadians have a significant appetite for this policy plan, which may form into the policy expectations of voters depending on how electoral and political trends continue to develop. Canadians may harbour this appetite due to frustration with the current pharmacoeconomic situation or because of a belief that pharmacare is in line with collective, ideological morals about the right to access healthcare. There is significant evidence that pharmacare's qualitative attraction may spur political will, exhibited by the Advisory Council pointing to it as being in line with "Canadian values." Further, there is significant data that suggest that citizens, regardless of province, place a high value on Canada's healthcare system and wish to see universalism expanded.[64] Thus, pharmacare is certainly feasible if observed through the lens of whether citizens may vote in candidates who campaign on universal drug coverage.

Despite this, there has been some varied discontent regarding pharmacare expressed by the media. In a survey of the top stories from each of Canada's ten most-read news sources, the National Post and the Calgary Herald were the two most anti-pharmacare sources. Despite the fact that it seems like most of the claims made by these papers are disputed by the scholarship on this topic, disregarding these sources would not give a whole picture of whether pharmacare is feasible in Canada. This is for one simple reason: media sources help shape public opinion, which shapes voting behaviour. Voting behaviour, as I have pointed to, is extremely pertinent to the feasibility of pharmacare, especially at the provincial level. Most articles in Canadian media that have expressed a negative view of pharmacare share basically the same criticisms of a national "monopolistic" policy: it is expensive, unnecessary, and could actually reduce access to care.[65] Additionally, local papers that operate in the Postmedia conglomerate continually publish negative content about the Liberals' path to Pharmacare, such as the London Free Press which emphasizes that "there's no need to wipe out a system that already works well for the vast majority... to help a few."[66]

As such, how will the media affect public opinion, which will certainly affect the appetite for pharmacare and how pressure is placed on the government? Kelly Blidook tackled this very question, exploring the extent to which the media affect public perceptions of "the way things are" in Canadian healthcare.[67] Blidook indicates that media use has a significant effect on public perceptions regarding the state of healthcare, especially when negative, meaning that the potential impacts of media on public perception regarding pharmacare is a significant factor when considering the future of its feasibility. If the majority of the media were to turn on pharmacare and the will of the people were to dictate the shape of public policy in Canada, as our liberal democratic structure suggests, pharmacare would likely not be feasible. Mapping the quantity of negative media that quantifies a threat to pharmacare is beyond the scope of this paper, which presents a limitation to my claims. However, it is clear that many media sources remain complimentary to

pharmacare thus far, and that the majority of negative reporting seems to be rooted in already solidly blue regions that are already slightly less likely to support pharmacare (for example, Calgary media sources). As a whole, the Canadian media does not seem to focus excessively on pharmacare in a negative light and many sources of media are quick to point out the advantages of pharmacare. Moreover, negative coverage seems to be highly regionalized and therefore less of a threat than if it were nationwide. Thus, in light of the present situation and given the current evidence, pharmacare remains a feasible option for Canadian healthcare. This may change in time given Blidook's findings, if voices in Canadian media significantly turn their favour against pharmacare, but that does not seem to be a significant risk at this time.

How will COVID-19 Impact Pharmacare?

The claims of this paper are based on literature, data, and government communications that predate the pandemic and fail to adequately consider how the pandemic might impact the implementation of pharmacare. Health spending, public prioritization of healthcare infrastructure, and parliamentary debate on healthcare have been at record highs throughout the first year of the pandemic and will likely to continue to be so in the near future. There are several possibilities about what the upshots of COVID-19 will be on the implementation of pharmacare, which I will now outline. Firstly, it is possible that healthcare may remain in the forefront of Canada's political collective consciousness, which could have the effect of shedding light and moving debate forward on pharmacare. In late 2020 and early 2021, there has been pressure placed on the Liberals by the New Democratic Party to get pharmacare off the ground, but the government thus far has not chosen to make decisions on pharmacare, focusing instead on vaccine rollouts.[68] After voting down a 2021 pharmacare bill proposed by the NDP, Trudeau has emphasized that the process of implementing pharmacare will not be imposed by the federal government, but will instead be inductive and involve intergovernmental cooperation. Partisan whips and provincial-federal boundaries may be slightly weakened in the fallout of COVID-19, as political actors realize that they may need to reach across the aisle and to different levels of governance to prioritize healthcare. This possibility, although idealistic, is a possible upshot because COVD-19 initially seemed to be spurring increases in governmental collegiality, which may have the potential to bleed into other topics (like pharmacare). This is indicated by the fact that Ontario's Conservative finance minister praised Trudeau's management of the pandemic and has promised to "stand shoulder-to-shoulder" with the federal government.[69] However, as the pandemic has progressed, the likelihood of this possibility has decreased as the adversarial nature of partisan politics and provincial-federal relations has essentially returned to full force. This indicates that the collegiality observed was a short-term, rally-around-the-flag-esque effect.

It is also possible that COVID-19 may slow or halt the implementation of pharmacare. First, COVID-19 may reaffirm the provinces' desire to have autonomy and independence in determining health policy, as leaders may see it as illuminating the differences between each province's healthcare infrastructure and quality. This is observable in BC and Alberta's refusal to adopt the federal government's contact tracing mobile application for free.[70] This may result in provinces being less willing to make concessions to the federal government for drastic new institutional policies or cash transfers, as they may wish to retain the ability to make decisions regarding formularies for future emergencies. However, this may also have the opposite effect, as provinces may be more willing to expand healthcare coverage for citizens upon realizing the importance of federal-level responses to health challenges. Second, parliamentary and public debate on health has been significantly directed away from pharmacare, as more airtime and debate in the House of Commons has been spent dealing with emergency responses to COVID-19. Thus, the salience of pharmacare in political discourse has been lowered, making it less likely to be implemented in the short-term. Lastly, federal and provincial healthcare budgets may be focused on fixing the vulnerabilities exposed by COVID-19, such as hospital bed numbers, staffing numbers, and technology. Thus, there might be less political will to put a "down payment" on pharmacare at this time.[71]

If COVID-19 were an infection that typically necessitated prescribed pharmaceutical drug therapy, this may be a different story, as a spotlight might have been shone on the inequalities and public health risks of inaccessible pharmaceuticals. However, due to COVID-19's viral nature and the fact that most patients who are prescribed medications receive them in hospitals (meaning that their drugs are already covered under the CHA), the inaccessibility of drug therapy has not become a key consideration. It is beyond the scope of this paper to make claims about the degree of certainty with which COVID-19 will impact pharmacare as this may be better analyzed by public healthcare and medical professionals. However, it is important to note that the pre-pandemic literature may be less applicable to the future state of health policy in Canada as the world moves forward.

Conclusion

The lack of a pharmacare system in Canada complicates its universal healthcare system and seems to run counter to its institutional and legislative healthcare principles. This paper has tackled why the Canadian system lacks pharmacare, showing that previous attempts have largely been unsuccessful because of a perceived lack of need or the lack of political will. It then turned towards examining the question of the feasibility of pharmacare, demonstrating that pharmacare is indeed feasible structurally and politically, given three key conditions: the existence of political will from the federal government to propel its inception forward, provision of funding, and the structuring of negotiations through cooperative policy-building. Additionally, political will must exist from the provincial-level government to collaborate with the federal government in a way that may mean giving up autonomy. Lastly, that media coverage of pharmacare does not turn public opinion against pharmacare, given the democratic nature of Canadian politics. Despite the feasibility of pharmacare, it is unclear how the federal government will go about delivering pharmacare to Indigenous peoples, as they are under the federal government's constitutional jurisdiction. There are clearly political actors across the political spectrum that aim to either propel or bring a halt to pharmacare's implementation. Although it seems like most evidence points to overall benefits of implementing pharmacare, there are valid concerns that go against implementing pharmacare. In any case, this paper concerned itself mainly with the feasibility of pharmacare, rather than the merits of its implementation. To this end, this paper concludes that pharmacare is feasible, but that there are complications with making any broad statements about pharmacare due to Canada's settler-colonial character and the uncertainty created by COVID-19.

Endnotes

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