Examining the Politics of Pharmacare: A Historical Institutionalist Perspective on the Development of Pharmacare Programs in Ontario and Quebec

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Abstract

Canada remains the only developed country with a universal healthcare system that does not include nationwide coverage for prescription drugs. Only recently has the question of enacting a universal pharmacare plan come to fruition on the floor of the House of Commons. However, issues raised recently by provincial governments, including those of Ontario and Quebec, highlight concerns about the fiscal arrangements and operationalization of the first phase of Bill C-64, *An Act Respecting Pharmacare*, and the subsequent establishment of the Canada Drug Agency by the federal government.

Through a cross-case analysis of existing pharmacare programs in Ontario and Quebec, I seek to determine how existing policy legacies and institutional structures have reshaped the political environment at the provincial level and have subsequently impacted the policy outcomes that may affect the prospect for contemporary federal reform for a national pharmacare program.

This thesis employs a historical institutional approach to explain the trajectory of policy development as it concerns the politics of pharmacare in Canada. Following the work of scholars such as Paul Pierson on policy feedback (i.e., the impact of existing policy legacies on contemporary politics and policymaking), I analyze three types of political actors: elite attitudes, interest groups, and mass publics to determine how they have been affected by Canada's fragmented system of drug financing, with a particular focus on Ontario and Quebec.

Résumé

Le Canada reste le seul pays développé doté d'un système de santé universel qui n'inclut pas de couverture nationale pour les médicaments. Ce n'est que récemment que la question de l'adoption d'un régime universel d'assurance-médicaments a été débattue à la Chambre des communes. Cependant, les questions soulevées récemment par les gouvernements provinciaux, notamment ceux de l'Ontario et du Québec, mettent en lumière les préoccupations concernant les arrangements fiscaux et la mise en œuvre de la première phase du projet de loi C-64, Loi sur l'assurance-médicaments, et la création ultérieure de l'Agence canadienne des médicaments par le gouvernement fédéral.

Grâce à une analyse croisée des programmes d'assurance-médicaments existants en Ontario et au Québec, je cherche à déterminer comment les héritages politiques et les structures institutionnelles existantes ont remodelé l'environnement politique au niveau provincial et ont ensuite eu un impact sur les résultats politiques qui peuvent affecter la perspective d'une réforme fédérale contemporaine pour un programme national d'assurance-médicaments.

Cette thèse utilise une approche institutionnelle historique pour expliquer la trajectoire du développement politique en ce qui concerne la politique de l'assurance-médicaments au Canada. En suivant les travaux de chercheurs tels que Paul Pierson sur la rétroaction des politiques (c'est-à-dire l'impact de l'héritage des politiques existantes sur la vie politique et l'élaboration des politiques contemporaines), j'analyse trois types d'acteurs politiques : les attitudes de l'élite, les groupes d'intérêt, et le public afin de déterminer comment ils ont été affectés par le système fragmenté de financement des médicaments au Canada, avec un accent particulier sur l’Ontario et le Québec.

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Chapter 1 – Introduction

1.1 The Need for Pharmacare in Canada

Canada's universal healthcare system more commonly referred to as 'Medicare' is one of Canada's most beloved institutions. Indeed, Canadian Medicare is regarded as a key symbol of Canadian identity (Tuohy, 2018). However, Canada remains an outlier amongst many of its Western liberal counterparts, such as the United Kingdom and Australia – which both include universal, single-payer programs for pharmaceuticals, also known as pharmacare, as a part of their healthcare systems. Instead, Canada remains the only developed country with a universal healthcare system that does not include nationwide coverage for pharmaceutical drugs (Boothe, 2018).

In the absence of a national drug insurance plan, provinces and territories began to develop their form of public subsidy programs for prescription drugs in the 1960s and 1970s by providing drug insurance for select vulnerable groups such as persons on social assistance and persons over the age of 65 (Brandt et al., 2018). Although universal public coverage for prescription drugs has been recommended by various national commissions since the 1960s, the federal government continues to rely on an incomplete patchwork of federal, provincial, and territorial drug programs which operate in conjunction with private insurance providers to provide drug coverage throughout the country (Lancet, 2019; Morgan and Daw, 2012).

Indeed, the public drug plans that are currently offered vary dramatically between the provinces and territories, demonstrating that Canada's lack of a comprehensive national drug plan has resulted in the inconsistency of drug coverage and disproportionate out-of-pocket expenses for pharmaceutical products, particularly for poorer and rural Canadians (Hajizadeh and Edmonds, 2020). Between Canada's federal government, ten provincial governments, and

three territorial governments, more than 100 public drug plans, and 100,000 private drug plans are offered throughout the country, based on varying eligibility requirements (MacNeil, 2023). Therefore, access to pharmaceuticals for many Canadians is largely based on their province of residency, their age, and their access to private insurance – the latter often granted through employment (Boothe, 2015). As the COVID-19 pandemic resulted in significant job losses throughout the country, with many losing access to their private health insurance as well, Canadians continue to fall through the gaps of Canada's fragmented system of drug insurance programs (Buajitti et al., 2022).

Since the establishment of Medicare in the 1960s, multiple studies and government reports have recommended that universal drug coverage ought to be included as a part of Canada's healthcare system. The most recent of these studies is Dr. Eric Hoskins' 2019 report of the Advisory Council on the Implementation of National Pharmacare, commonly known as the Hoskins Report, which called on the federal government to work with provincial and territorial governments to establish a universal, single-payer public system of prescription drug coverage in Canada (Hoskins Report, 2019).

In response to the Hoskins Report and the increasing public pressure to improve access to drug coverage across Canada, the March 2022 supply-and-confidence agreement between the Liberal Party of Canada and the New Democrat Party features the issue of pharmacare prominently. This reality led to the tabling in February 2024 of Bill C-64, *An Act respecting pharmacare*, as the first step towards improving universal coverage for drugs, marking a pivotal change in the political landscape of pharmaceutical coverage in Canada (Health Canada, 2024). *An Act respecting pharmacare* proposes the foundation for the establishment of a universal pharmacare system in Canada and constitutes the funding principles for the creation of the

Canadian Drug Agency, formally known as the Canadian Agency for Drugs and Technologies in Health, a federal body that is now concerned with developing a list of essential prescription medications and a national bulk-purchasing strategy for the federal government. Currently, the bill proposes the first steps in the federal government's plan to coordinate with the provinces and territories to provide first-payer coverage of some contraceptive and diabetes medication. The pharmacare bill has passed its third reading in the House of Commons and is now headed to the Senate for review (CTV News, 2024).

However, jurisdictional arrangements that define how Canada's Medicare system is financed is very likely to complicate the establishment of a national pharmacare plan. For instance, alongside other provinces, Ontario and Quebec have both stated their hesitancy to join a national pharmacare strategy. Even before Bill C-64 was tabled in the House, Quebec's Coalition Avenir Québec (CAQ) government announced that they would be opting out of the new federal program entirely to retain complete jurisdiction over the funding arrangements of the province's existing pharmacare program. The Ontario Progressive Conservative government, on the other hand, has not yet decided whether it would opt out of the plan, but remains hesitant on signing onto the federal agreement, citing that "Our government prefers to wait to see what the federal government is going to propose by way of a pharmacare program before we say what our position will be on that," (Robin Martin, Parliamentary Secretary to the Minister of Health of Ontario, quoted in CBC, 2024). These reactions from Canada's two largest provinces, Ontario and Quebec, highlight concerns about the fiscal arrangements and operationalization of the first phase of Bill C-64 and, by extension, the subsequent establishment of the Canadian Drug Agency. Therefore, it is clear that substantive federal policy reform on pharmacare is directly

impacted by the existing policy legacies[1] that lie within current provincial pharmacare programs in Canada.

1.2 Brief Historical Overview of Medicare in Canada

In the post-war era, proposals to establish a plan to nationalize the delivery of healthcare services in Canada began through the policy efforts of former Saskatchewan premier Tommy Douglas, who argued that healthcare, should be based on need rather than the ability to pay (Surtees, 2021). Introduced by Premier Douglas and his social democratic party, the Co-Operative Commonwealth Federation, the predecessor of the New Democratic Party, the implementation of the first universal hospital insurance plan in North America was established in 1947, effectively changing how healthcare is conceptualized as a part of the larger social welfare state.

In response to Douglas' efforts to standardize the delivery and quality of healthcare throughout Saskatchewan, the *Hospital Insurance and Diagnostic Services Act* was passed by the Parliament of Canada in 1957. It provided a 50/50 cost-sharing provision for provincial and territorial hospital insurance plans to reimburse provincial and territorial governments for specific hospital and diagnostic services (Flood et al., 2018). For the first time in Canadian history, publicly administered universal coverage for hospital care was provided through substantial federal government financing efforts.

The federal Liberal government, in agreement with provinces and territories, passed the *Medical Care Act* of 1966 which marked a pivotal shift in the Canadian psyche – that the federal government ought to provide provinces and territories with expenditure for insured hospital and

[1] Policy legacies is a descriptive term and not an explanatory concept referring to potential causal mechanisms, which is what "policy feedback" is, as it refers to mechanisms through which existing policies (i.e. policy legacies) might shape politics and policymaking over time (Campbell, 2018).

physician services (Government of Canada, 2019). The Act offered to provide reimbursement payments of one-half of provincial and territorial costs for medical services administered by doctors outside of a hospital setting. Within six years of the Act, every province and territory in Canada had established single-payer insurance plans to cover physician services (Flood et al., 2018). Saskatchewan's hard-fought battle to include healthcare as an intrinsic Canadian value is commonly attributed as "Saskatchewan's gift to Canada" (McIntosh, 2001, 1).

As a legislative successor to the *Medical Care Act*, the *Canada Health Act* of 1984 was passed to replace prior hospital and medical insurance acts and to consolidate the principles of criteria by which all provinces and territories must abide to receive their block fund transfer payments, a combination of tax points and cash payments, to fund their respective healthcare systems (Flood et al., 2018).[2] The five principles of Canadian Medicare outlined within the Act are: a) public administration, b) comprehensiveness, c) universality, d) portability, and e) accessibility (Canada Health Act, 1985). Additionally, the *Canada Health Act* prohibits extra billing and user fees for insured services by provincial and territorial governments (Flood et al., 2018).

As a federation, Canada grants significant political power and policy responsibility to its provinces and territories. *The British North America Act* of 1867[3] established the Dominion of Canada as a constitutional monarchy with a federal system of government (The British North America Act, 1867). Section 91 of the Act grants the federal government exclusive powers, with the following section, Section 92, entrenching matters of provincial jurisdiction, including

[2] The block fund transfer was established in 1977 through the Established Programs Financing (EPF). This marked a departure from the shared-cost (50/50) approach of the *Medical Care Act* of 1966. The Canada Health Act built on this financing program and addressed its negative consequences in terms of provincial behaviour. The program's funding requirements were then made on condition to respect the five criteria of the Canada Health Act and introduced provisions for the federal government to withhold funding to provincial and territories that did not reach the criteria (Government of Canada, 2023).

[3] In 1982, this Act was renamed the *Constitution Act* of 1867.

provincial taxation. Although healthcare is not assigned directly as a legislative power to either Parliament or to the provincial legislatures, the Constitution does relate some powers to the delivery of healthcare. For example, Section 92(7) of the Constitution assigns the responsibility for the provinces to establish and maintain the upkeep of most hospitals (Butler and Tiedermann, 2011). Therefore, the structure of the healthcare system is reliant on constitutional power divided between federal and provincial jurisdictions. However, in 1939, through the Royal Commission on Dominion-Provincial Relations, it was concluded that the delivery of healthcare services was determined as a matter of provincial responsibility, funded in large part by the spending power granted by the federal government (Flood et al., 2018).

One of the defining features that shape health policy in Canada is the institution of federalism. Federalism is a political system in which government powers and responsibilities are constitutionally divided between national and subnational governments (Richard, 2005). Each level of government retains certain powers over various jurisdictional affairs as described within a constitution and cannot be amended unilaterally by one level of government (Wildasin, 2004). Federalism, therefore, defines the division of power over financial and jurisdictional affairs that accentuate the necessary relationship between different levels of government required to counter regional inequalities, without threatening the political autonomy of one governmental body over another. The *Canada Health Act* is one of many pieces of federal legislation that detail the jurisdictional and financial relationship between the federal and provincial governments as it relates to the functionality of Medicare in Canada.

In the Canadian context, the delivery of healthcare services occurs through a system of disaggregated federalism in which most of the constitutional responsibility for the delivery of healthcare services is assigned to the provinces (Flood et al., 2017). It has been argued that this

constitutionally defined division of responsibility for the financing and subsequent delivery of healthcare services by the provinces, through the funding power granted by the federal government, has enabled the federal government to play a larger role in the expansion of social programs, including healthcare, without directly threatening provincial or territorial autonomy (Lecours and Béland, 2010; Surtees, 2021). Whilst some people, including and especially the government of Quebec, have argued that the ability of the federal government to use its spending power to aid in the service delivery of healthcare services discourages the province's ability to establish innovative and diverse social welfare programs, others believe that all Canadians, regardless of where they live, deserve access to the national standards of healthcare delivery and care set forth by the federal government (Palley and Forest, 2004). The result of this belief is the mosaic of Canada's thirteen different healthcare systems, all of which share various pan-Canadian features (Hirdes, 2001).

In the aftermath of the 1995 federal budget, which witnessed major cuts in federal transfers, the Government of Canada provided financial support to provincial and territorial governments for healthcare through the Canada Health and Social Transfer. The Canada Health and Social Transfer was a single block fund sent by the federal government to provinces and territories in support of health care, among other social services, so long as they complied with Ottawa's strict criteria as outlined in the *Canada Health Act* (Gaulthier, 2012). Since 2004, the Canada Health Transfer and the Canada Social Transfer have existed side by side as separate programs and the former has been entirely dedicated to federal healthcare funding to the provinces and territories according to a block grant logic (Government of Canada, 2023).

Since the patriation of the Canadian constitution in 1982, equalization payments, which first began in 1957, are enshrined in the Canadian constitution stating that: "Parliament and the

Government of Canada are committed to the principle of making equalization payments to ensure that provincial government have sufficient revenues to provide reasonably comparable levels of taxation" (Constitution Act 1982, Subsection 36 [2]). Despite the changes that have occurred to the conditionality of the Canada Health Transfer, the federal government maintains its position that for provinces and territories to receive federal contributions, in the form of block transfers to their provincial or territorial insurance plans, they must abide by the criteria entrenched within the *Canada Health Act* (Marchildon and Mou, 2014).

What continues to remain strikingly absent in the Canadian Federation's history of Medicare, and the greater expansion of federal expenditure for the social welfare state, is the exclusion of federal funding for prescription drugs (Maioni, 2015). The following half-century after Medicare was established, debates continue to persist concerning the possible reasons as to why Canada has failed historically to provide federal funding for prescription drugs. Despite the constitutional division of powers that determine the jurisdictional responsibilities of provincial and territorial governments, the idea of a national pharmacare program has remained a contested issue between different political parties, and various levels of government throughout Canadian history (Boothe, 2018).

Certainly, Ontario and Quebec's lackluster response towards a national pharmacare program serves as a reminder that jurisdictional disputes between subnational and national governments affect the necessary political relationship that is required to provide essential, first-payer coverage of healthcare services, including medication, to all Canadians. Furthermore, the institutional structures and policy legacies that lie within the current pharmacare programs in Ontario and Quebec should help determine how the federal government might standardize and

provide equal access to qualifying medications across Canada. This is the central hypothesis of this thesis.

1.3 Research Objectives and Questions

Through a cross-case analysis of existing pharmacare programs in Ontario and Quebec, I seek to determine how existing policy legacies and institutional structures have reshaped the drug programs in both provinces and their potential impact on the development of Canada's newly proposed national pharmacare plan. To determine how policy legacies at the provincial level affect the current policymaking process at the federal level, my thesis will employ a historical institutionalist lens and, more specifically, policy feedback theory (Pierson, 1993). As suggested, it is important to examine how the establishment of public policy at the federal level might be influenced by the development of the provincial pharmacare plans in Ontario and Quebec, particularly since the 1990s.

The central objective of my thesis is to analyze moments in history that have affected the development of each province's pharmacare policies to illustrate the potential political consequences that the federal government will have to consider in the rollout of a national pharmacare plan. In the following chapters, I seek to advance the literature on policy feedback theory by examining the influence of existing provincial policy legacies and their influence on federal reform public policy processes concerning the historical development of provincial pharmacare programs with a focus on Canada's two largest provinces, Ontario and Quebec. The research questions for this thesis are:

1. What are the gaps in coverage of existing provincial pharmaceutical programs in Ontario and Quebec, and how is the federal government seeking to bridge such gaps?

2. How do the policy legacies of the current pharmacare programs in Ontario and Quebec affect the prospect of the implementation of a national pharmacare plan?
3. More specifically, what potential political challenges to the implementation of such a plan are derived from the policy feedback effects of existing Ontario and Quebec pharmacare programs?

1.4 Methodological and Theoretical Approaches

Following De Percy (2020), I argue that historical institutionalism, as an analytical approach, can provide a better framework in the examination of the impact of existing policy legacies on contemporary political issues. Specifically, historical institutionalism will act in this thesis as a tool for comparative analysis, as it will help uncover the differing effects that existing policies and institutions, which lie within the provinces of Ontario and Quebec, have on the policymaking process at the national level. As historical intuitionalists seek to generate answers to substantive questions about the history and sequence of policy development over time, analyzing the historical events and political actors which have greatly influenced the development of drug policy in Ontario and Quebec will aid in providing necessary insights to explain how existing policies inevitably shape the development of other policies – particularly at the intergovernmental level.

Historical institutionalism is a qualitative analytical approach that focuses on political and policy institutions from a historical standpoint, including how temporality and the sequence of events affect the development of institutions in their ability to help shape social, political, and economic policymaking outcomes (Fioretos et al., 2016). Scholars of this research tradition typically seek to explore political phenomena through the lens of path dependency – that is, the establishment of a policy through the sequence of events – to analyze how they become reliant

on one another to inform their developmental processes (Pierson and Skocpol, 2002). In this way, historical institutionalism can aid in the discussion to determine how and when policy change occurs, and the subsequent forces that have prevented it.

Because my thesis seeks to focus particularly on the effect that existing policies that lie within the provinces have on policy outcomes at the federal level, my research is informed greatly by the policy feedback theory, which emerged within historical institutionalism and is consistent with its historical and institutional approach to politics and public policy (Béland, et al., 2022; see also Pierson, 1993; Skocpol, 1992). I argue that policy feedback, that is the causal mechanisms through which existing policies can create the potential to shape the politics of public policy over time, has influenced the political dialogue concerning pharmacare policy reform at the federal level. Therefore, this thesis will argue that the existing provincial policy legacies of Ontario and Quebec, as it concerns the endogenous factors which are derived from the historical development of their individual pharmacare programs, has directly affected the prospect for federal pharmacare reform.

Following Skocpol (1992), I argue that policy feedback theory enables historical institutionalists to determine how public policies have reshaped social and political actors' capacity to maintain, expand, or reverse the prospect of those policies over a long period of time. Similarly, policy feedback theory can be utilized to determine the viability of whether such policies are likely to be maintained, expanded upon, or reversed in the future.

However, as argued by Jacobs and Weaver (2015), historical institutionalists have become overly concerned with self-reinforcing policy feedback processes, that is, the way in which policies themselves can affect politics through, "bolster[ing] their own bases of political support, yielding either policy stability or an expansionary dynamic over time" (443). They

argue instead that self-undermining policy feedback processes, the mechanisms in which politics, "yield consequences that *undermine* their base of support," can also influence the likelihood of policy change over time (443).

Greif and Laitin (2004) suggest that policies can affect political institutions in both a self-reinforcing and self-undermining way. Indeed, as long-term self-reinforcing policy feedback effects may grant policy stability or policy expansion, they can, at the same time, yield policy rollback of reorientation effects through long-term self-undermining policy feedback processes (Jacobs and Weaver, 2015). Therefore, it is possible, particularly in utilizing a historical institutional approach, to witness the operation of self-reinforcing and self-undermining feedback dynamics, which can take place simultaneously, in policy development processes (Jacobs and Weaver, 2015).

For this thesis, I seek to determine what self-reinforcing policy feedback effects have encouraged mass public support on the issue of pharmacare and have subsequently enabled the federal government to develop a national pharmacare program in recent years. Similarly, in this thesis, I seek to determine what self-undermining policy feedback processes have made the development of a national pharmacare plan a challenge for the federal government and have subsequently discouraged some of the provinces from initially opting into the program.

To assess whether and how self-reinforcing and/or self-undermining policy feedback effects are derived from provincial pharmacare programs in Ontario and Québec and may have affected federal prospects for reform on the implementation of a national pharmacare strategy, I will also be using process tracing as a research method. As defined by Collier (2011), process tracing is a qualitative research method that seeks to identify the processes that determine the causal mechanism between a cause and its outcome. Using process tracing to study both self-

reinforcing and self-undermining feedback effects over time will enable me to identify explanatory factors and policy outcomes that lie within these provinces to determine the discrepancies between programs. In turn, I will then be able to identify how the federal government is seeking to reduce the gaps between pharmacare programs in Canada through the adoption of a national pharmacare strategy.

My thesis intends to advance the larger dialogue of healthcare policy development in Canada and its consequential effects between various levels of government, therefore, to conduct my process tracing analysis of potential self-undermining and self-undermining feedback effects in Ontario and Quebec, I will draw on both primary and secondary literature. This will include government documents, including provincial and federal legislation, reports of royal commissions, parliamentary committees, healthcare reports, and so forth. This will also include a literature review that discusses the effect of government reports, policy proposals, and other academic publications surrounding the issue of federal-provincial relations and its effect on pharmacare policy development in the Canadian context.

1.5 Case Selection

For my thesis, I chose to analyze two case studies to underpin the comparative aspect of this research. Demographics, fiscal capacity, administrative capacity, and their longstanding cultural relationship with Ottawa since Confederation legitimize the selection of Ontario and Quebec for this thesis. Although both Ontario and Quebec provide public subsidies for certain prescription drugs, they have a different system of financing that administers coverage through different age, employment and income bases. Furthermore, Ontario and Quebec remain the most populous and politically powerful provincial governments in the country in which, respectively, 39% and 22% of the Canadian population reside (Statistics Canada, 2024). Therefore, what they

have already done concerning the development of their pharmacare programs is especially important to consider from both a national and intergovernmental standpoint.

First, Ontario was chosen as a case study due to its high population size, large fiscal capacity, and the increasing privatization of healthcare services, particularly under the governance of Premier Doug Ford (Babony, 2019). Therefore, Ontario is a necessary case study to examine the public-private dichotomy that has affected the inability of the province to achieve a universal pharmacare system and further explains why the current Ontario government is hesitant to join a national pharmacare strategy. Second, I chose the province of Quebec, which has long been known for its continuous desire to defend and expand its provincial jurisdiction – particularly in the realm of healthcare. Quebec has routinely defended its provincial autonomy within the Canadian federation, which is exemplified by Quebec's adoption of its private-public drug coverage system in 1997 (Palley and Forest, 2004).

Chapter 2 – Literature Review

In Chapter 2, I provide a review of existing literature on the current policy windows that have prompted the federal government to take the issue of a national pharmacare program seriously. Additionally, I highlight the literature that explores the barriers to pharmacare reform, and the political and economic challenges the federal government must consider in the proposition of a national pharmacare strategy in Canada. Finally, to draw comparisons between the development of provincial pharmacare programs in Ontario and Quebec in the following chapters, I conclude the literature review with a discussion on the policy feedback theory to show that policies that have been established at the provincial level might directly affect federal policy reform processes, in both a self-reinforcing and a self-undermining way (Jacobs and Weaver, 2015).

1.1 A National Pharmacare Program: Why Now?

Scholars who have examined the structural reform of the Canadian Medicare system have pointed towards the implementation of a universal pharmacare plan as the avenue needed for Canada to deliver more adequate and equitable health delivery services throughout the country (Brandt et al., 2018; Hartmann et al., 2018; Morgan and Boothe, 2016). However, pharmacare has risen on the national policy agenda many times since the 1960s in Canada, with virtually every national commission on healthcare calling for some form of a national drug plan to be established. Such commissions include, but are not limited to, the Hall Commission (1964), the National Forum on Health (1997), the Kirby Commission (2002), the Romanow Commission (2002), and most recently, the Advisory Council on the Implementation of National Pharmacare (2019) (Law and Clement, 2024). Despite the repeated calls for the establishment of a national drug plan that has continued over the past 50 years since the adoption of Canadian Medicare, Canada has only recently developed a pharmacare plan – so why now?

Advocates for the adoption of a Medicare program in Canada during the 1960s argued that such a program, without the adoption of a national pharmacare strategy, would result in a catastrophic number of premature deaths in the country (MacNeil, 2023). Indeed, the Canadian Federation of Nurses Union estimates that hundreds of Canadians continue to die every year simply because they cannot afford the medication and supplies that they need to survive. In a 2018 report, the organization found the lack of affordable medication results in up to 640 premature deaths of working-age Canadians every year (Canadian Federation of Nurses Union, 2018).

It is the most vulnerable Canadians, particularly those living on or below the poverty line, who suffer the most from predatory costs associated with the rising unaffordability of life-saving

medication. Indeed, one in five Canadians struggle to pay for their prescriptions, and over three million Canadians do not fill their prescriptions at all and cite their unaffordability as a significant barrier (Hoskins Report, 2019). Disabled Canadians are disproportionately affected by the cost of pharmaceuticals and medical supplies — many of which are not covered by their provincial Medicare plans or by their private drug insurance plans. According to Gupta et al., (2020), nearly one-third of disabled Canadians purposely skip and ration their prescriptions or do not fill their prescriptions at all due to cost. MacNeil (2023) argues that the supply costs of special medical equipment, that most Canadians do not have to think about, such as catheters, dressings, and gloves contribute to the overwhelming financial burden that is commonly associated with various chronic illnesses, such as cancer, heart disease, and diabetes.

Since 2018, the issue of pharmacare has become a topic of discussion in the Canadian Parliament with multiple national and provincial organizations calling on the federal government to immediately adopt a national pharmacare strategy (MacNeil, 2023). Indeed, in the wake of the 2019 federal election, a coalition of 170 national and provincial organizations published a joint document titled the *Pharmacare Now Statement* to push the Liberal government to adopt legislation that would establish a national pharmacare strategy (Canadian Health Coalition, 2020). In February 2020, one month before the COVID-19 pandemic, federal New Democrat Member of Parliament Peter Julian sponsored Bill C-213, *An Act to enact the Canada Pharmacare Act*, a private member's bill which called upon the federal government to implement a public pharmacare program free from insurance sector involvement (Parliament of Canada, 2020). The bill was ultimately defeated at second reading in the House of Commons on February 24, 2021.

The COVID-19 pandemic has certainly exposed the financial strains on the healthcare systems in various liberal welfare regimes, including Canada (Béland et al., 2021). As highlighted by the Organisation for Economic Co-operation and Development (OECD), the COVID-19 pandemic caused massive and sudden economic deterioration across the globe, forcing federal governments to enact swift policy actions in an effort to support recovery within their respective countries (OECD, 2021). In Canada, over eight million Canadians applied for the Canada Emergency Response Benefit (CERB) program during the pandemic (Canada Revenue Agency, 2021). Therefore, more recent scholarship concerning the advent of a national pharmacare strategy has pointed to the COVID-19 pandemic as a key critical juncture[4] for policymakers, at both the federal and the provincial level, to tackle Canada's pharmaceutical problem (Fierlbeck, 2023; Greer et al., 2023).

The co-operation between major government elites, including and especially political parties, in the design and implementation of temporary emergency measures to combat the financial stresses experienced by Canadian families during the COVID-19 pandemic, has led to increased social policy expansion. In an effort to keep the governing minority Liberal government in power, the federal New Democrats agreed upon a supply-and-confidence agreement in March 2022 that sought to provide the Liberals with political security during votes of no confidence under the conditions set forth by the New Democrats (Béland and Massé, 2024). One particular condition of the agreement was the enactment of a national pharmacare program through a national formulary and bulk purchasing plan (Liberal Party of Canada, 2022). However, the supply-and-confidence agreement has highlighted the contentious relationship

[4] A critical juncture, "may be defined as a period of significant change, which typically occurs in distinct ways in different countries … and which is hypothesized to produce distinct legacies (see Collier and Collier, 1991).

between various social policy actors, with varying ideological backgrounds, in achieving significant structural reform of Canada's Medicare system.

Institutional agreements such as the contemporary supply-and-confidence agreement are extremely rare in Canadian politics due to the contention concerning policy concessions which force larger governing parties to succumb to the policy demands of minor parties in exchange for voting support in Parliament (Paun and Hibben, 2017). The contemporary supply-and-confidence agreement between the federal Liberals and the New Democrats has been labeled a "window of opportunity" to establish more coordinated and comprehensive drug coverage in Canada (Law and Clement, 2024 8). In this way, the supply-and-confidence agreement can be regarded as a critical juncture in contemporary Canadian politics to tackle the country's lack of a national pharmacare plan.

However, the *Delivering for Canadians Now* agreement has been met with much criticism due to its unbinding terms. The Liberal-New Democrat pact is not a coalition, rather it is simply an agreement of policy compromise meaning that New Democrats, including party leader Jagmeet Singh, do not hold any official seats in the governing cabinet, although the New Democrats are permitted to dissolve the agreement if their conditions are not met. The policy proposals which have been established, including the Dental Care initiative, have resulted in much public scrutiny, with one Edmonton-based journalist calling the rollout of the pact's policy program a "means-tested mess" (Jeremey Appel, independent journalist, quoted in Jacobin, 2024). Notwithstanding the proposition to enact the *Pharmacare Act*, it has been repeatedly delayed, including the original deadline for the program, which was initially set to be tabled by the end of the 2023 calendar year (Zimonjic, 2024). The slow and incremental roll-out of the national pharmacare program shows that the current proposition of a federal bulk purchasing

plan for pharmaceuticals will likely be a lengthy, drawn-out process – experiencing significant deterrence in its adoption by provincial and territorial governments.

1.2 Debates on the Barriers to Pharmacare Reform

As highlighted by Béland and Tombe (2023), provincial delivery of healthcare services is significantly dependent on federal funding efforts enabled through the Canada Health Transfer. However, various factors, including the increasing rate of an aging population, have put a significant fiscal strain on the provinces and territories, which have in turn, compelled premiers to ask for an increase in health-related transfer payments by the federal government (McIntosh, 2021). As healthcare delivery is largely a provincial responsibility, negotiations between the provinces and the federal government are essential to the operations of a national pharmacare strategy. Moreover, because providing drug coverage remains a provincial domain, access to pharmaceuticals across the country is intrinsically reliant on healthy intergovernmental negotiations and shared fiscal governance in order to support Canada's increasingly strained healthcare system.

Canada's political system of federalism has been continuously cited as a primary explanation for the country's lack of a universal pharmacare plan due to the impact that provincial-federal relations have on establishing major institutional changes within the Canadian healthcare system (Flood et al., 2018). Indeed, intergovernmental relations have posed a significant barrier to policy reform as policymakers, between national and subnational levels of government, have historically found it difficult to achieve a consensus on health policy related to the advancement of a national pharmacare strategy. However, Katherine Boothe (2018) argues that there have been four major opportunities in Canada (in 1964, 1972, 1997 and 2002) in which

the federal government struck down a national pharmacare strategy before putting forward its proposal to the provinces and territories.

Boothe's insightful article shows that attributing the historical failure of a national pharmacare strategy to the institution of federalism alone remains unsatisfactory (Boothe, 2018). Although cooperation with the provinces and territories is required in a federal structure to make a significant update to Canada's Medicare system, such as the implementation of a national pharmacare program, possible provincial opposition alone does not provide an adequate analysis of the various times that an elite consensus at the federal level has exclusively blocked proposals for pharmacare reform, and have consequently placed pharmacare as a low place on the federal political agenda (Boothe, 2018). In this way, Boothe (2018) shows that a lack of an elite consensus between federal political parties, and even within governing parties themselves, has acted as an important barrier to pharmaceutical policy reform at the national level.

Another recurring barrier to pharmacare reform is the argument that a national pharmacare program is too costly for Canada. However, much scholarly work concerning Canada's pharmacare problem shows the large net savings that the country would save through the development of a national pharmacare program (Boothe, 2018; Morgan et al., 2015). For example, Morgan et al (2015) argue that establishing a national pharmaceutical plan in Canada could save the private sector, which has a consequential stake in the establishment of a national pharmacare strategy, nearly $8.2 billion annually. Despite its projected cost of roughly $3.4 billion per year in additional health funding for the Canadian government, they argue that the establishment of a national pharmacare strategy would grant the federal government the ability to reduce the cost of generic drugs, branded medication, and supply greater product selection

effectively providing the federal government with substantial net savings which they could use to fund other aspects of the Canadian healthcare system (Morgan et al 2015).

Indeed, the establishment of a national pharmacare strategy has long been argued to be a benefit to Canada's pharmaceutical patchwork system. Not only would the establishment of such a program help equalize insurance coverage for pharmaceuticals between provinces and territories, which all have drastically different pharmacare programs based on varying eligibility requirements, it would also enable the federal government to have the purchasing and negotiating power against private insurance companies to lower the cost of life-saving medication (Boothe, 2018). In this context, the federal government decided to tackle the pharmacare problem in 2018 through the House of Commons Standing Committee on Health Report, which concluded, upon other recommendations, that federal expenditure arrangements as outlined in *Canada Health Act* should be expanded upon to include pharmaceuticals (House of Commons Standing Committee on Health, 2018, 84).

Following the publication of that report, the Advisory Council on the Implementation of National Pharmacare (ACINP) was created. Chaired by former Ontario Minister of Health and Long-Term Care Dr. Eric Hoskins, the council made sixty recommendations covering thirteen different areas of interest and called on the federal government to establish a comprehensive national pharmacare strategy by 2027. Importantly, the Council was not created to endorse a national pharmacare plan as a good policy idea for the federal government, but rather, to recommend a model of pharmacare that would work in Canada, based on existing domestic and international models of pharmacare (Hoskins Report, 2019).

The report concluded that the federal government ought to establish a federal bulk purchasing plan through the development of the Canada Drug Agency, a pan-Canadian health

organization responsible for coordinating and aligning existing drug policy programs between provinces and territories (Health Canada, 2023).[5] Additionally, the Hoskins Report highlights the important relationship between subnational governments and relevant stakeholder groups, particularly pharmaceutical manufacturers and private drug insurance groups, which the federal government must consider in the adoption of a national pharmacare plan (Hoskins Report, 2019).

The most important aspect of the Hoskins Report details the necessary intergovernmental collaboration that is required in the development of a national pharmacare program. The report recommended that so long as provinces and territories comply with the standards agreed upon with the federal government, the federal government will exchange funding dollars and continue the trend of conditional funding transfers to subnational governments, only this time to help provide drug coverage for medication outlined within the national drug formulary (Hoskins Report, 2019). Therefore, the recommendations made within the Hoskins Report, show that swift intergovernmental collaboration is essential to the quick and effective delivery of a national pharmacare plan whilst respecting the jurisdictional integrity of the provinces and territories.

1.3 Political and Economic Considerations for Pharmacare Policy Development

It remains abundantly clear that, despite the recurring debates on the barriers to adopting a national pharmacare plan, the patchwork of private and public drug benefit plans in Canada is becoming an increasing strain on the country's most vulnerable populations – providing an opportunity for private insurance companies to continue to drive up costs for life-saving medication (Law et al., 2013). Currently, the provinces and territories retain jurisdictional power

[5] To be clear, although the establishment of the Canada Drug Agency is new, it will be built from the work previously done by the Canadian Agency for Drugs and Technologies in Health (CADTH). The Canada Drug Agency will expand on its predecessor's work to improve pan-Canadian data collection and strengthen coordination efforts between the federal government and provinces and territories in the development of a national pharmacare program (Canada Drug Agency, 2024).

to provide pharmaceutical coverage which is established through current bulk purchasing agreements with private insurance companies (Gagnon and Hébert, 2010). However, Lybecker (2013) shows that a single, united federal bulk-purchasing agreement would not only provide better access to more affordable medication for provincial and territories to secure more favourable deals for Canadians, but it would also increase the federal government's collective purchasing power against predatory drug insurance companies and pharmaceutical manufacturers.

Similarly, Morgan and Daw (2012) note that the exclusion of prescription drug coverage since the development of Canadian Medicare in the 1960s has caused the private insurance industry to mobilize against the adoption of a national pharmacare strategy and act as a strong influence on opposing federal policy reform processes. Crosby et al (2016) note that although steps have been taken to standardize drug prices and coverage across the country through the Pan-Canadian Pricing Alliance,[6] private insurance groups have continued to exert a strong control on the market for prescription drugs that lie within the provinces which has undoubtedly led to the deterrence of the implementation of a national pharmacare program for many decades. They argue that the relationship between private drug companies and provincial and territorial public drug plans makes it increasingly difficult for the federal government to negotiate with powerful drug insurance and pharmaceutical manufacturers. As the provinces retain the bargaining power to standardize drug prices and are subsequently responsible for providing drug coverage for their constituents, it is clear that private sector interests has acted as a key player, at both the federal and provincial levels, in the institutional deadlock of achieving a national pharmacare strategy in Canada (Angus and Karpetz, 1998).

[6] The Pan-Canadian Pharmaceutical Alliance is an alliance between the provinces and territories which seek to combine their bargaining power against pharmaceutical manufacturers to lower and standardize prices on drugs.

The assortment of plan coverage across the country has also resulted in Canada paying some of the highest costs in the world for pharmaceuticals. Compared to other industrialized countries, a 2014 joint study conducted by the University of Ottawa and Bruyère Research Institute found that the costs associated with six of the most common drugs used to treat high blood pressure and high cholesterol are nearly twice as expensive in Canada as they are in other liberal welfare states, including the United Kingdom and Australia (MacNeil, 2023). As recently as March 2023, drug spending in Canada has surpassed spending on physician remuneration and is now quoted by the federal government as being its second largest cost, after hospitals, in the Canadian healthcare system (Government of Canada, 2023). Shockingly, the Organisation for Economic Co-Operation and Development asserts that Canada pays over 25% above the organization's median for pharmaceuticals (Health Canada, 2023).

1.4 Policy Feedback Theory

Following E. E. Schattschneider's early twentieth-century observation that "a new policy creates a new politics" (1935, 288), scholars of historical institutionalism have utilized the policy feedback theory to describe how policies influence political behaviour and subsequently inform the development of new policies (Béland et al., 2022). However, as argued by Paul Pierson (1993), political scientists have been slow to incorporate Schattschneider's insight, and rather tend to treat new policy development as an effect of the policymaking process – not the other way around. Instead, Pierson's 1993 influential thesis on policy feedback theory suggests that policies ought to be treated as a cause of political behaviour, emphasizing that "policies produce politics" (597). Pierson's thesis serves as a reminder to comparative political scientists that examining policies themselves as an explanatory variable is best to understand how political struggles, particularly concerning the establishment of new policy ideas, come to be.

In his discussion, Pierson (1993) argues that "researchers have not clearly specified the range of ways in which policies can affect politics [and] they have often failed to identify important paths of influence" (597). His main quarrel with the existing scholarship is that policies in and of themselves must be seen as consequential political institutions. However, he remains clear that the impact of policy development often occurs in conjunction with other variables. As important as it is to view political consequences, such as existing policies, as a cause of policy development, Pierson (1993) highlights two significant additions to the policy feedback theoretical framework. First, he states that individual policies tend to take on multiple characteristics, and therefore can affect politics in a multiplicity of ways. Second, he states that policy feedback rarely operates in isolation from other variables within a political environment. Therefore, the policy feedback framework is essential to the political science theory-building practices which can help explain the ways in which existing policies can help facilitate, or impede, the emergence of new policies.

As noted by Béland et al (2022), the concept of policy feedback that emerged in the late 1980s and early 1990s coincided with the bulk of literature that arose during the establishment of historical institutionalism within public policy research. Originating in the United States, historical institutionalism focuses on political and policy institutions from a historical standpoint, taking particular attention to the temporal sequence of institutional processes and their impact over time (Pierson, 2004). Historical institutionalism is largely based on comparative and international research as it stresses the impact of how institutions, that is, embedded norms and rules, including public policies, vary between and within cases over time (Béland et al., 2022).

In this way, policy feedback theory, which has its roots developed within historical institutionalism, helps identify how policies can have a societal norm-setting effect. In turn,

policy feedback theory argues that effects from existing policies can establish dominant attitudes within a population, which can effectively establish a self-reinforcing feedback loop between attitudes and policies, with policies acting as both a cause and effect of political behaviour (Mettler and Sorelle, 2014). Therefore, policies can form a structure of path dependence that is hard to reverse, meaning that policies themselves can act as a powerful force which can create a substantial impact on a political environment by encouraging policy stability over time (Greif and Laitin, 2004).

However, the development of new policies does not always yield policy stability or expand over time. Although policy feedback scholars such as Pierson (1993) state that policies can create social and political conditions in which such policies are likely to be maintained or expanded upon, it is possible that policies may be weakened, causing their political viability to be diminished. As argued by Béland et al (2022) and Jacobs and Weaver (2015) policy feedback is not always self-reinforcing, as changing economic and social circumstances can make policies designed in a certain way become less and less durable over time.

Instead, Jacobs and Weaver (2015) argue that policy feedback processes can occur in a self-undermining way as endogenous factors, which may stem directly from the policy itself, can generate strong adverse consequences on the survival of the policy itself. In this way, policies can also be self-undermining – policies can interact with features embedded within institutional or organizational arrangements which may force governments to either maintain or reverse existing policies. Moreover, it is possible that the same policy can interact with existing arrangements that can be self-reinforcing and self-undermining at the same time (Greif and Laitin, 2004; Jacobs and Weaver, 2015). Therefore, both processes can occur simultaneously and can subsequently yield significant insights into policy development over time.

As noted by Jacobs and Weaver (2015), “Where policy reform occurs, self-undermining effects may explain *why* change emerged; self-reinforcing effects, meanwhile, will often offer a compelling account of why reform takes the specific *form* that it does” (454). In utilizing this insight, I seek to identify the important historical and institutional paths of influence that the provinces of Ontario and Quebec have taken in the development of their pharmacare programs in Chapters 3 and 4. I will then show, in Chapter 5, how feedback effects from existing pharmacare policies in Ontario and Quebec might have influenced the prospects for a national pharmacare plan in Canada.

Chapter 3 – Pharmacare Policy Legacies in Ontario

Ontario is the largest province with a mix of income-based and age-based pharmacare plans that target different age and income demographics, and whose programs have been considerably influenced by the private sector. These programs will be explored in this chapter to explain how the historical evolution of Ontario’s drug policies has resulted in new policy effects in which the federal government must consider in the adoption of a national pharmacare plan.

1.1 Ontario’s Age-Based and Income-Based Drug Plans

The Ontario Drug Benefit Program is the largest existing program in the province which seeks to provide drug coverage to those who require the most financial support for pharmaceuticals, particularly those over the age of 65 and who are low-income (Government of Ontario, 2024). The Ontario Drug Benefit Program covers the cost for approximately 5,000 prescription drug products as listed within the Ontario Drug Benefit Formulary for the following demographics in the province: Ontario residents over the age of 65; Ontario residents under the age of 24 who are not covered by a private plan; residents of long-term care homes and homes for special care; recipients of professional home services; recipients of social assistance; and

recipients under the Trillium Drug Program (Government of Ontario, 2024). The Ontario Drug Benefit Program is an umbrella program that encompasses all the other age and income-targeted programs in the province, and it is the largest public drug plan in Canada (Busby and Robson, 2011).

The cost-sharing requirements under the Ontario Drug Benefit Program require a $100.00 annual deductible[7] for single seniors with an annual net income equal to or greater than $22,000 and for senior couples with a combined annual income equal to or greater than $37,100 with a fixed $6.11 co-payment[8] dispensing fee per prescription (Government of Ontario, 2024). For low-income seniors, the Ontario Drug Benefit deductible can be waived, and co-payment fees reduced to $2 through the Seniors Co-Payment Program, for seniors who do not reach the income eligibility threshold mentioned above (Government of Ontario, 2024).

In recent years, the provincial government has made an expansion to the Ontario Drug Benefit program through the Ontario Health Insurance Plan Plus (OHIP+). Since January 2018, the Ontario government has provided more than 5,000 drug products as listed within the Ontario Drug Benefit Formulary at no cost for anyone age 24 years or younger who is not covered by a private plan. However, Ontarians who meet the age requirements, but are covered even minimally through a private plan including their parent's private plan, are ineligible to receive any pharmaceutical coverage through this program (Government of Ontario, 2024).

Additionally, the Government of Ontario offers a broader income-based deductible program, the Trillium Drug Program, which offers catastrophic coverage for Ontarians between the ages of 25 to 64 who spend 4% or more of their after-tax household income on prescription

[7] A deductible is another word for out-of-pocket costs that are required to be paid before insurance providers will pay an expense.
[8] Co-payment fees are the percentage of an insurance claim that the insured must pay irrespective of the claim amount. It is interchangeable with "co-insurance."

drug costs (Government of Ontario, 2024). This program seeks to provide additional provincial expenditure for those with exceedingly high prescription costs, however, deductible coverage through the Trillium Drug Program is only available to households that do not have private insurance plans which do not provide 100% drug coverage for out-of-pocket expenses.

Ontario's income-based and age-based drug policies are only an aspiration to provide universal coverage for pharmaceuticals within the province. Because the province does not have an integrated framework for cost-sharing between public and private payers, there exist varying sources of coverage for different populations which has resulted in a fragmented system, leaving many Ontarians to fall within the cracks of the province's patchwork of drug programs (Nauenberg and Yurga, 2023). In fact, Ontario's patchwork of public and private programs has left approximately 2.2 million Ontarians without any type of drug coverage at all (Sellathurai 2024). Ontario's mix of age and income-targeted public drug programs, which rely upon their constituents having access to comprehensive private employer-provided benefits plans, has significantly affected the development of drug policy in Ontario.

1.2 Policy Legacy Trends Concerning Ontario's Public Drug Models

The complex arrangement of prescription drug coverage in Ontario exists in the absence of a national pharmacare program. Ontario's public drug programs operate in a hybrid model that seeks to provide comprehensive coverage for seniors and young adults, while providing income-based coverage for everyone else (Morgan et al., 2013). In 1974, the Ontario government established the Ontario Drug Benefit Program, whose aim, at the time, was to provide free prescription drugs to seniors and recipients of other government income supplement programs (Lexchin, 1992). For example, by 1975, the program provided first-dollar coverage to all Ontario residents aged 65 and older. However, by the late 1980s, increasing criticism of the program

began – largely from the Ontario Ministry of Health who noted that the program was raising annual expenditure costs for the provincial government. Indeed by 1988, the annual cost for the program exceeded $400 million – from just under $59 million a decade earlier (Ontario Ministry of Health, 2024). Burdened by the significant federal reduction in health transfers to the Ontario Medicare program throughout the 1980s, then-Minister of Health, Elinor Caplan, launched the Pharmaceutical Inquiry of Ontario, also known as the Lowy Inquiry, to examine expenditure costs related to prescription drugs in Ontario (Lexchin, 1992).

In their investigation concerning the accelerating costs of the Ontario Drug Program, the inquiry found that between 1976 to 1989 the cost of the program had increased by 313.8% – accounting for almost 5% of total provincial healthcare expenditure by the end of the decade (Pharmaceutical Inquiry of Ontario, 1990). Additionally, the report found that the Ontario Drug Benefit Program provided coverage for 15-20% of Ontarians, and 60% of Ontario residents received drug coverage through private health insurance plans obtained through their workplace, leaving nearly 20% of Ontarians uninsured and having to pay out-of-pocket for prescription drugs (Deber and Thompson, 1992). Importantly, the report acknowledged that despite the increase in government expenditure costs for the Ontario Drug Benefit Program, the report concluded, upon several recommendations from community leaders, that the program ought to be expanded to include government social assistance program recipients and other subgroups that do not receive third-party coverage through private insurance companies, to increase access to prescription drug coverage across the province (Hurley and Johnson, 1991).

In the 1990s, policy alternatives to public drug programs in Ontario were focused on modifications to existing provincial drug benefit programs for seniors and those on social assistance, rather than the establishment of a universal pharmacare program in the province.

Indeed, rising income inequality and population aging which have been on the rise since the 1980s had become a greater concern for the provincial government. Moreover, as highlighted by Cardy (2017) between 1990 and 2000, the cost of prescription drugs rose by 9.2% a year, presenting a serious concern to provincial governments tasked with the responsibility of financing their public drug programs. Therefore, the provincial government chose to expand access to existing programs to reduce the gaps in access and affordability, as well as reducing the high costs for prescription medication paid for by public and private insurers, instead of adopting a provincial pharmacare strategy (Toronto Public Health and Wellesley Institute, 2018).

To expand access to the Ontario Drug Benefit Program, the Ontario government introduced the Trillium Drug Program in 1995 to provide catastrophic coverage for Ontarians with high drug costs relative to their income. In 2018, the provincial government introduced the Children and Youth Pharmacare plan to additionally expand drug coverage to those under the age of 25. However, a major limitation of Ontario's mix of targeted drug coverage programs acts as a substantial barrier to social and economic mobility for the most vulnerable citizens (Daw and Morgan, 2012). As demonstrated by Nauenberg and Yurga (2023), when provincial governments such as Ontario have multiple programs that target different sectors of the population, the effectiveness of the programs themselves becomes weaker and in turn limits the government's ability to negotiate with the private sector to lower the costs of pharmaceuticals in the province.

1.3 Discussion on the Policy Effects of Ontario Pharmacare Programs

The complex arrangement of publicly funded drug coverage programs that currently exist within Ontario creates uneven access to prescription drugs across the province. Although seniors in Ontario may be able to receive public subsidies to cover prescription drug costs, 23% of Ontario residents aged 65 and older reported having no prescription insurance coverage in 2021

(Statistics Canada, 2022). Up until the late 1990s, seniors in Ontario received universal, almost first-dollar public drug coverage, however, population aging remains a possible financial liability for the provincial government. This reality has led to recent policy decisions made by the province in an attempt to curb government expenditure for their public drug programs. including their decision to increase cost-sharing requirements for seniors. For example, the Ontario government will increase the Seniors Co-Payment income eligibility threshold from $22,200 to $25,000 for single seniors, and $37,100 to $41,500 for senior couples effective August 1st, 2024 (Government of Ontario, 2024). This policy decision which will increase the income thresholds for low-income seniors will inevitably cause many to lose access to the program and could have grave consequences for the healthcare system in Ontario for many years to come.

In the 2017 provincial budget, the Ontario Liberal government introduced its version of an age-based pharmacare plan for Ontario residents that would cover the full costs for those under 25 with no co-payments or deductibles (Ferguson, 2017). However, as they lost the 2018 spring election, the incoming Progressive Conservative Party government decided to restrict the eligibility requirements to only those without any access to private drug plans, including those who have access to a private drug plan through parental coverage (Miregwa et al., 2022). This significant modification to the Ontario Health Insurance Program for young people, which has been in place since April 2019, illustrates the province's continued shift towards a more multi-payer system, without tackling access and equity problems for Ontario youth who lack access to comprehensive drug coverage.

There have been significant arguments made that state that Ontario's age-targeted public drug programs do little to address the inefficiencies, particularly for those under the age of 25 (Cardy, 2017). In their study on the use and costs of public drug plans among youth in Ontario,

Miregwa et al (2022) found that between December 2017 (before program modification) to October 2019 (after program modification) the percentage of program beneficiaries in their sample study decreased from 57.2% to 53.4% for youth aged 0 to 17. Less than two years after the program's introduction, 3.8% of children in Ontario lost access to the program, likely due to the program modification established by the Doug Ford Progressive Conservative government.

Moreover, Ontario's mix of public drug programs has put significant financial pressure on the government. Per capita, drug expenditure in Ontario is approximately $1,259 per person, the fifth highest in all of Canada (Mikulic, 2023). In the 2021-22 fiscal year, the Government of Ontario spent $5.3 billion on their public drug programs and subsequently reported that the projected spending will total an estimated $7.2 billion by the 2027-28 fiscal year (Government of Ontario, 2023). Public expenditure of Canada's largest public drug program will likely continue to put pressure on the provincial government due to the continual increase of drug costs, and the growth in the number of Ontario residents aged 65 and older over the course of the next few years.

While 77% of Ontarians report having access to drug insurance coverage either through a public plan, private plan, or a mix of the two, Ontario's multi-payer system relies on the assumption that all employers provide some form of drug coverage (Angus Reid Institute, 2020). However, those who work precarious low-wage and part-time jobs often are not provided with drug benefits by their employer (Morgan and Boothe, 2016). For example, Bolatova and Law (2019) note that only 58.7% of respondents self-reported having private insurance that covered all or part of their annual prescription costs in Ontario. They also found that respondents with a higher household income were more than three times as likely to report having access to private drug insurance plans than lower-income households. Additionally, a 2020 Angus Reid Institute

study found that 20% of respondents from Ontario reported having to pay out-of-pocket for prescription medication due to the lack of comprehensive drug coverage. They note that lower-income households are more than twice as likely (at 37%) to have paid more than half of the cost of their prescriptions as compared to households who have an annual income over $100,000 (at 15%). Therefore, income-related disparities in both private and public prescription drug coverage are significantly notable in Ontario.

The assortment of public drug plans in Ontario leaves many to fall through the cracks of Ontario's multi-payer system with 25% of surveyed Ontario respondents noting that they face significant barriers to accessing prescription drug coverage in the province (Angus Reid Institute, 2020). Unsurprisingly, the same surveyed respondents in Ontario agree (at 77%) that a national pharmacare plan would help to provide comprehensive coverage for Ontarians who experience significant barriers to access due to the mix of public and private plans in the province.

Indeed, Ontario faces tough challenges with the intersection of fiscal and health policy. As the number of seniors continues to grow, and healthcare costs continue to increase, the province faces a difficult battle in the coming years to provide adequate access to drug coverage to its most vulnerable populations. Ontario's mix of targeted, insurance-based and catastrophic drug coverage models has left significant policy shortcomings in the province that the federal government will have to consider in the rollout of a national pharmacare plan.

Chapter 4 – Pharmacare Policy Legacies in Quebec

Unlike the Hoskins Report that prescribes a single-payer government solution to Canada's lack of a national pharmacare program, Quebec's existing pharmacare program relies on a mixed public-private system called the *Régie de l'assurance maladie du Québec* (RAMQ), which is tasked with administering public health and drug insurance plans in the province

(Labrie, 2019). The historical evolution of Quebec's public-private policy legacies will be explored in this chapter to describe how drug policies have resulted in new policy feedback effects that the federal government will have to consider in the adoption of a national pharmacare plan.

1.1 Quebec's Employment-Based Drug Plan

To provide all Quebecers with access to a basic prescription drug insurance plan, in 1996 the *Act Respecting Prescription Drug Insurance* established the first pharmacare program in North America. Titled the Public Prescription Drug Insurance Plan, all Quebec residents who do not have access to a private drug insurance plan are granted prescription drug coverage through the province (Governement du Québec, 2020). Unlike Ontario, Quebec does not have an age-based or income-based public plan. Rather, Quebec residents, who do not have access to a private plan, are required by law to pay into a premium-based public plan administered by the *Régie de l'assurance maladie du Québec* (Morgan et al., 2013). In this way, all workers and retirees are required to purchase some form of prescription drug coverage, whether that be a private insurance plan through their occupation, or through the public plan to ensure that all Quebec residents have access to some form of drug coverage.

Cost-sharing in Quebec is unique compared to other provinces and territories. Since July 1st, 2024, the Public Prescription Insurance Plan has required individuals to pay an annual premium between $0 and $744 per person, depending on one's net family income (Governement du Québec, 2024). Quebec residents who are beneficiaries of the public drug program are required to pay monthly deductibles of $22 per adult with a co-insurance payment of 32% of the prescription cost minus the deductible, where applicable (Gouvernement du Québec, 2020).

Therefore, the government requires Quebec residents to pay a maximum contribution[9] amount of $99.65 per month, or $1,196 per year (Gouvernement du Québec, 2024).

The Quebec government requires that all employers must offer basic drug coverage that matches the drug coverage offered by the province as outlined within the Public Prescription Drug Insurance Plan. This means that all private insurance coverage offered by employers must include coverage for the essential medications outlined within Quebec's drug formulary (Gouvernement du Québec, 2020). The Quebec government also grants employers and associations the choice to offer group insurance to their employees or members and subsequently allows for the employer to make an agreement with its insurer on the conditions of the plan, such as the percentage of coverage and the eligibility criteria.

The private plan eligibility criteria for employers in Quebec can include restricting access to those who do not reach the minimum hours worked or dictating exclusions to their drug coverage plans for employees who have part-time or casual contracts (Gouvernement du Québec, 2020). Additionally, if an employee does not qualify for the plan offered by their employer or association, they are required by law to register with another plan, including their spouse's private drug plan. In this way, the Quebec government requires that its residents provide an official letter from either their employer, occupational group or from another private insurer, to ensure that they are receiving their legally mandated prescription drug coverage. Taxpayers who cannot receive drug coverage through an employer or occupational group, are required to identify on Line 447 of the provincial income tax form, to define their eligibility for the public plan.

[9] If one purchases prescription drugs covered within the provincial public plan, a maximum contribution amount is the portion of the costs (contribution) that is required to be paid by the patient.

Currently, there are 1.8 million Quebecers who obtain coverage through the province's public drug plan (Canadian Health Coalition, 2022). Compared to the national average of 5.5% of Canadians who cannot fill their prescriptions because of unaffordability, Quebec has the lowest percentage of patients, at 3.7%, who claim to not fill their prescriptions due to the financial cost (Law et al., 2018). Therefore, public coverage obtained through Quebec's drug plan is regularly cited as being the most generous public drug plan in the country (Kapur and Basu, 2005; Labrie, 2019; Pomey et al., 2007). This is largely due to the Quebec government's drug formulary that provides over 8,000 prescription drug products, which is comparatively less restrictive and more extensive than other provinces in Canada, including Ontario (Gouvernement du Québec, 2024).

Despite Quebec's unique public drug insurance model, that does provide the most substantial drug coverage in comparison to other provinces and territories in Canada, the most vulnerable Quebecers, including welfare recipients, the chronically ill, and low-income seniors can still be required to pay a substantial amount for the necessary medication that they need to survive. Due to the central role that private insurers and the pharmaceutical lobby have in providing drug coverage across the province, predatory insurance costs are often cited as a significant barrier to access for vulnerable Quebecers (see Gorecki, 1993; McPhail and Bubela, 2023). Moreover, Quebec's public drug plan, which operates only if their constituents lack access to a private insurance plan, the province has, unsurprisingly moved further away from a pan-Canadian agreement on the development of a national pharmacare plan.

1.2 Policy Legacy Trends Concerning Quebec's Private-Public Drug Model

Before Quebec installed its public-private drug model in 1997, there existed several drug insurance programs that provided different forms of coverage for different segments of the

population. For social welfare recipients and seniors over the age of 65, Quebec's main public programs provided complete drug coverage in an attempt to alleviate financial pressures for the province's most vulnerable populations well into the 1990s (Ferguson, 2018). Although 4.5 million Quebecers were provided private drug coverage by their employers during this time, nearly 1.5 million citizens, equaling 20% of the province's entire population, could not access sufficient drug coverage due to the lack of a comprehensive pharmacare program in the province (MSSS, 1995).

Following the recommendations set forth by the National Forum on Health (1997) that called for the federal government to expand Canadian Medicare to include prescription drug access without charging deductibles or copayments, Quebec sought to provide its own version of a pharmacare plan due to the impending threat of federal oversight onto the Quebec healthcare system (Labrie, 2019). Additionally, the resurgence of Quebec nationalism during the 1990s, which exacerbated regional discontent concerning welfare state development, effectively pushed the government elites in the province to retain its constitutional jurisdiction on Quebec's healthcare system through the development of its private-public drug coverage model (Béland and Lecours, 2005).

Quebec's current drug insurance model originated from previous provincial efforts to address the patchwork of public drug plans in order to target the inequities and inefficiencies in the province's healthcare system (Martin, 1996; Morgan, 1998). From 1993 to 1995, the province's Liberal and then Parti Québecois governments commissioned three separate reports which concluded that more targeted assistance programs, and subsequently, a universal, catastrophic drug coverage model would not provide better access to drug coverage throughout the province (Pomey et al., 2005). Despite public support to adopt a universal public drug plan as

the appropriate solution to provide equitable drug coverage in the province, the Quebec government struck down such a plan due to the perceived political risks, particularly from pharmaceutical manufacturers and drug insurance companies who argued that the adoption of a universal public drug plan would wreak financial havoc on the province, who at the time, were experiencing a diminish in federal health transfers from the federal government (Morgan et al., 2017).

Boychuk and Banting (2008) argue that private health insurance companies have played a significant role in the historical development and implementation of public health programs in liberal welfare regimes such as Canada and have significantly impacted the "fill-the-gaps model" that many provinces, including Quebec, use to provide drug coverage through a private-public funding model. Indeed, Quebec opted to create a legal framework to enable private insurance companies to provide drug coverage to the majority of the working force population, whilst establishing a public assistance program for everyone else (Labrie, 2019). Quebec's private-public system of drug coverage can be considered a policy compromise for the province: residents were able to access a publicly funded drug insurance program if they could not receive drug coverage from their employer, without increasing public spending on pharmaceuticals for the government– a critical decision made at a time when global drug prices were growing rapidly (Morgan et al., 2017). Those who already had workplace coverage for prescription drugs – which constituted roughly 60% of the working-age population in Quebec before 1997 – could keep it, and those who could not access an employer-based drug program could therefore be covered under the new public program – paid through general provincial taxation revenue (Canadian Health Coalition, 2022).

1.3 Discussion on the Policy Effects of Quebec's Pharmacare Program

The effects of Quebec's drug insurance model, particularly its appeasement to avoid conflict with industry stakeholders, have increased the access to drug coverage for some of the population whilst decreasing access for others. For example, the latest national survey data shows that the implementation of Quebec's policies provides its residents with the highest rate of drug insurance coverage for both working-aged men and women at 88.8%, as compared to the national average of 81.1% (Statistics Canada, 2024). However, observational studies found that seniors and recipients of social assistance are more likely to experience financial barriers due to the rising cost of pharmaceuticals throughout the province (Blais et al. 2003; Tamblyn et al., 2001). For example, in 2014, 6.6% of Quebecers aged 65 and older reported that they did not fill their prescriptions because of cost, as compared to 4.1% of other Canadian residents of the same age demographic (Lee and Morgan, 2017). Furthermore, in 2021, 30% of Quebec residents aged 65 and older reported that they did not have prescription drug insurance as compared to the national average of 25% (Statistics Canada, 2022). Morgan et al (2017) argue that the Quebec government's choice to reduce user charges for working-age recipients of social assistance in 2002, and the following decision to eliminate user charges in 2007, has resulted in disproportionate access, particularly for seniors, to low-cost pharmaceuticals in the province.

Additionally, Morgan et al (2017) demonstrate that Quebec's system of prescription drug coverage results in financial inequity between low-income and high-income households. As private drug coverage is a mandatory requirement in Quebec, low-income households may be subject to high-cost premiums, which are often higher than the premiums set by the public drug plan and can equal 10% or more of someone's annual income (Roy, 2017). Because an employer or professional organization may choose to offer group-specific pooling to its members, private premiums are often lower for members of wealthier groups than for members of less wealthy

groups, including part-time workers (Morgan et al., 2017). Additionally, Quebec's drug policies can have a disproportionate effect on low-income households due to the monthly deductibles and coinsurance changes that often burden low-income families. As noted by Luffman (2005) between the enactment of Quebec's drug plan in 1997 to 2002, households who spent more than 3% of their after-tax income on prescription drugs rose from 7.6% in 1997 to 9.5% in 2002. Moreover, as noted by the Angus Reid Institute (2015; 2020) 32% of Quebec households reported that they spent more than $500 on out-of-pocket prescription drugs, which is 13% higher than the reported national average.

Another major insight from Quebec's drug policy legacies is the efficiency of the province's ability to manage total system costs, that is, government and non-government expenditures on pharmaceuticals. In 2023, Quebec spent $1,358.50 per capita on pharmaceuticals – the highest in all of Canada (Mikulic, 2023). As argued by Morgan et al (2017), per capita health expenditure tends to vary based on prices available and product selection as set by the provinces themselves, rather than the number of medications actually prescribed to patients.

As stated by Morgan et al (2017), the landscape of prescription drug expenditure in Quebec has significantly changed since the province implemented its private-public drug insurance system in 1997. Before 1997, pharmaceutical spending by the provincial government was not always drastically higher than in other Canadian provinces. Rather, Quebec's previous public age-based and income-based drug plans, which operated similarly to the programs that currently exist in Ontario, were financed through government general revenues, i.e. taxation, which ultimately made the private and public premiums, as well as the user charges, comparable to those in other Canadian provinces.

However, Quebec's choice to adopt a private-public system of drug insurance has disproportionately increased deductibles, coinsurance rates and premiums for its most vulnerable citizens. It has also limited the incentives and capacity for the government to achieve reasonable cost control of pharmaceuticals in the province, which has in turn, resulted in the highest prescription drug costs in the country (Brandt et al., 2018). Indeed, it is reported that the Quebec government spends more than $200 per person than the rest of Canada to provide prescription drug coverage to its residents (Morgan et al., 2017).

Quebec's drug insurance model has resulted in a high degree of fragmentation which limits the provincial government's ability to negotiate with pharmaceutical manufacturers and insurance companies to reduce patient costs. Although the Quebec government does set requirements that employers must abide by in offering private insurance coverage to their employees, including offering the best available price for medication, the current multi-payer system that operates within Quebec does not allow for the government to receive rebates on behalf of insurers due to confidentiality agreements bound by Quebec law (Brandt et al., 2018). Essentially, Quebec's drug policies burden employers with the responsibility to negotiate the high costs of drugs with the pharmaceutical manufacturers directly, which in turn, forces Quebec residents to pay more for drugs than the average Canadian household. Therefore, Quebec's policy decisions to include compulsory private insurance for prescription drugs has made it additionally difficult to achieve progress on a national pharmacare plan (Pomey et al., 2007).

As stated by Morgan et al (2017), the only real winners of Quebec's drug policy legacies are industry stakeholders such as large pharmaceutical manufacturers and insurance companies who profit from Quebec's private-public drug model. Although Quebec's drug policy legacies have successfully increased drug insurance coverage through expanding access for employed

working-age adults, and through providing some form of coverage for everyone else, Quebecers remain enthusiastic about supporting the adoption of a national pharmacare plan. For example, a 2020 Angus Reid Institute study found that 87% of survey respondents in Quebec would strongly or moderately support their provincial government's participation in a national pharmacare program.

Therefore, drug policies that exist within Quebec have not only encouraged its constituents to strongly advocate in favour of a national pharmacare plan, but the province's public-private model has also affected the federal government's ability to adopt such a program due to the imperative role that industry stakeholders have on the ability to influence drug prices in the province. Moreover, Quebec's fill-the-gaps model of drug financing generates mixed results in terms of accessing low-cost medication and subsequently increases government expenditure, demonstrating that strong political leadership in the province is required to ensure that the goals of access, equity, and efficiency, as defined core values within Canada's Medicare system, are prioritized over private interests.

Chapter 5 – Comparative Discussion on Provincial Pharmacare Policy Legacies

In Chapter 5, I describe the policy feedback effects garnered from the policy legacies of existing pharmacare programs in Ontario and Quebec, which I argue have acted in both a self-reinforcing and self-undermining way. Drawing on the distinction between self-reinforcing and self-undermining feedback effects (Jacobs and Weaver, 2015), I argue that in some ways, policy feedback effects derived from provincial pharmacare policy legacies have become stronger, whereas others have become weaker over time. I show how elite attitudes, interest groups, and mass publics are shaped by policy feedback effects in both provinces to describe the potential

political challenges that the federal government will have to consider in the adoption of a national pharmacare plan.

1.1 Elite Attitudes

The fragmentation of prescription drug financing that exists across the country has established clear discrepancies in drug coverage between programs, leaving Canada to pay some of the highest prices for pharmaceuticals and one in five Canadians without access to drug coverage (Hoskins Report, 2019). This reality has certainly legitimized calls for the federal government to tackle the country's longstanding pharmaceutical problem. Therefore, the current federal government's plan to establish a national formulary and a national bulk purchasing strategy shows that elite attitudes have been shaped by the policy effects of Canada's patchwork of pharmacare programs. Exemplified in both the case studies of Ontario and Quebec, policy feedback processes have acted in a self-undermining manner, making provincial systems weaker while encouraging the New Democratic Party and, perhaps, the Liberal Party of Canada to embrace the idea of a federal single-payer pharmacare program as a valid policy alternative to messy and fragmented provincial policy legacies.

Ontario's compilation of targeted, insurance-based and catastrophic drug coverage public models, rely significantly on their constituents having access to employer-based health benefits and leave many without access to any drug insurance coverage. Additionally, the fragmentation of Ontario's public pharmacare programs has lessened the ability of the federal government to negotiate with drug insurance companies and pharmaceutical manufacturers to drive down price rebates for prescription drugs, which subsequently forces patients to pay higher rates for their medication than they would if they were covered by a national public drug model. All these remarks point to the existence of self-undermining feedback effects in Ontario.

Similarly, Quebec's system of prescription drug financing is also highly fragmented, which has consequential effects on prescription drug access to vulnerable groups in the province. Although Quebec's model of mandatory insurance purchase does result in a high percentage of overall population coverage, low-income households and other subgroups who may rely on drug coverage through the province's public plan are disproportionately affected by high co-insurance and deductible charges. As a result, total prescription drug expenditures continue to grow in Quebec forcing the provincial government to pay a higher price for drugs, which is another example of the provincial self-undermining feedback effect.

The discrepancies in existing pharmacare programs in both Ontario and Quebec are significant: it forces vulnerable groups such as seniors, children and low-income households to face significant barriers in accessing drug coverage. The self-undermining policy feedback effects caused by the discrepancies in public drug programs between provinces highlight the perceived need for federal intervention to lower prices for pharmaceuticals and achieve cost savings for both the provincial and federal governments. Therefore, the self-undermining feedback effects of Ontario and Quebec's pharmacare programs have legitimized federal government involvement by strengthening the elite attitudes on the left of the political spectrum about the idea that the existing patchwork of pharmacare programs remains fundamentally incompatible with the principles of Canadian Medicare enshrined in the *Canada Health Act*.

However, in some ways, policy feedback effects derived from the policy legacies embedded within provincial pharmacare programs have also acted in a self-reinforcing manner making it increasingly difficult for the federal government to establish a national pharmacare program. For example, Quebec's adoption of its contemporary drug policies in 1997, in the same year as the National Forum on Health, shows that historically government elites in the province

have been less interested in joining a national pharmacare plan. Therefore, Quebec's decision to design its own pharmacare program, over considering or pushing for a national initiative, shows that elite ideas in the province towards the viability of a national pharmacare plan have acted as a significant self-reinforcing policy feedback mechanism, which weakens the drive for the adoption of a federal single-payer drug insurance plan.

1.2 Interest Groups

In the 1960s, when the federal government adopted Medicare, it failed to entrench a single-payer program for drug coverage. In the following decade, provinces began to develop their own public pharmacare programs in the absence of a federal pharmacare plan. However, many of the provincial pharmacare programs only sought to provide coverage for specific vulnerable sectors of the population, effectively forcing the workforce population to rely extensively on private drug coverage instead. Therefore, the fragmentation of pharmacare programs across the country has continued to reinforce the power of private actors, specifically pharmaceutical manufacturers and drug insurance companies.

In the few last years, private sector interests have continued to persist. For example, in Ontario, age-based and income-targeted programs have left a considerable portion of the province without drug coverage effectively forcing Ontarians to rely extensively on private drug insurance programs to fill this void. Due to major policy changes to these programs including the current Progressive Conservative government's decision to limit access to Ontario's age-targeted drug insurance program for youth, private sector involvement in the development of the province's public drug programs is clear. Therefore, private sector interests have been significantly shaped by self-reinforcing policy feedback effects of Ontario's public drug programs, which have reinforced these vested interests over time, making it potentially harder to

implement path-departing policy alternatives that would reduce their role in pharmacare development.

In Quebec, the relationship between the private sector and the province's system of drug coverage could not be clearer. Since 1997, Quebec has legally mandated that employers provide private drug coverage to their employees in an effort to reduce public spending on medication and decrease financial strain on hospitals. Indeed, mandatory private drug coverage has eliminated some of the financial burden from the public sector by shifting the costs onto the shoulders of employers to provide drug coverage. As insurance companies are reimbursed by the provincial government to provide these private drug plans to employers across the province, it essentially incentivizes insurance companies to increase premiums to further grow their profit margins. Therefore, like in Ontario, Quebec's public-private pharmacare programs have directly encouraged private sector interests to strengthen over time. As Quebec continues to pay the highest costs per capita for its public-private drug coverage model, drug insurance companies and pharmaceutical manufacturers remain the main beneficiaries of this fragmented fill-in-the-gaps system, which constitutes a self-reinforcing feedback effect that creates strong incentives for these private actors to oppose path-departing change such as a federal single-payer system.

Because the private sector has become deeply entrenched in provincial pharmacare programs across the country, it is unsurprising that pharmaceutical manufacturers and drug insurance companies are seeking to keep Canada's current fragmented system of drug financing in place. Industry lobbyists, at both the federal and provincial levels, have previously sought to keep the existing patchwork of pharmacare programs in Canada so that they can continue to increase their profit margins, and that trend continues today (Boothe, 2013). Therefore, a national bulk purchasing strategy could threaten the profit margins of pharmaceutical manufacturers, as it

would enable the federal government to become the primary price negotiator and subsequently lower prices for pharmaceuticals for Canadians. Moreover, a national, single-payer system would threaten the financial incentives that private drug insurance companies have benefitted from for decades. Developing a national single-payer plan could wreak havoc on the profit margins that private industry stakeholders make within Canada's existing patchwork of pharmacare programs.

Policy feedback effects from existing pharmacare programs have directly shaped interest groups. On the one hand, the private sector interests have been reinforced as the patchwork of programs has enabled them to have considerable power in increasing insurance and drug prices. However, policy feedback effects derived from the fragmentation of programs have also acted in a self-undermining manner for interest groups. The development of a national pharmacare program is likely to significantly affect the profits that interest groups make in providing drug insurance coverage. Therefore, the federal government will have to consider the role that the private sector has developed in providing access to drugs and insurance within provincial pharmacare programs. In this way, the implementation of a national pharmacare program is likely to cause policy rollback of the existing provincial pharmacare programs, or at least, significantly reorient the role that interest groups play within them, throughout the country.

1.3 Mass Publics

Post-World War II policy decisions to adopt a single-payer system for hospital insurance and, later, medical insurance, have gained considerable public support for entrenching Medicare as a core component of the Canadian welfare state today. Similarly, provincial pharmacare programs, which have left many without access to comprehensive drug coverage have increased public opinion support for the current proposal of a national pharmacare program. Both examples, the former featuring self-reinforcing effects for Medicare and the latter self-

undermining effects for existing fragmented pharmacare arrangements, show that mass publics have been shaped by policy feedback effects derived from policy legacies embedded within provincial healthcare systems.

In recent years, public perception of the importance of addressing pharmacare-related issues in the Canadian healthcare system has increased as Canadians are continuing to be burdened by high deductibles and out-of-pocket drug expenses. Indeed, public opinion polls have suggested that Ontarians and Quebecers overwhelmingly support the idea of a national pharmacare program (Angus Reid Institute, 2020; Pollara Strategic Insights, 2023; Canseco., 2024). The contemporary surge in favourability over the last few years towards a national pharmacare program is likely due partly to millions of Ontarians and, to a lesser extent, Quebecers who are unable to access comprehensive drug insurance in their province (Heart and Stroke Foundation, 2023). Therefore, the assortment of the thousands of drug programs that exist across Canada, which leave millions of Canadians uninsured or underinsured, suggests that public support to adopt a national pharmacare program is a direct causal effect of the gaps in drug coverage embedded within Canada's patchwork of pharmacare programs.

However, the surge in public support from mass publics in recent years on the issue of a national pharmacare plan could be affected by temporal constraints. If the federal government cannot successfully negotiate the conditions for the rollout of a national pharmacare strategy with the provinces, it is possible that public support could quickly diminish, especially if premiers can successfully blame the federal government for this failure. Similarly, if the adoption of a national pharmacare plan threatens the existing drug coverage that Canadians already receive, particularly through their employer, it is possible that the idea of pharmacare could be perceived as unfavourable in the future.

In this way, policy feedback effects garnered from Ontario and Quebec's pharmacare programs have strengthened constituents' favourable policy perceptions of the necessity for the federal government to adopt a national pharmacare plan. However, if the adoption of a national pharmacare program threatens existing drug coverage that Canadians already receive through historically and institutionally embedded provincial public-private arrangements, it could weaken public support for national pharmacare. Only time will tell if the federal government is able to construct a successful policy response that addresses Canadians' desire to fix the shortfalls in drug coverage access whilst offering the conditions that match the ones already offered, by most if not all, of the numerous provincial public and private plans that already provide coverage to so many people across the country.

Chapter 6 – Conclusion

1.1 Thesis Overview

The fragmentation of prescription drug financing illustrated through the cases of Ontario and Quebec has effectively resulted in 13 different healthcare systems fostering clear discrepancies in drug coverage. In turn, the patchwork of pharmacare programs across Canada has enabled long-term self-reinforcing and self-undermining policy feedback processes to emerge over time. Long-term self-undermining policy feedback effects including the discrepancies between programs, the strengthening of private sector influence, and the barriers to accessing drug coverage, have encouraged public support to increase, which has subsequently forced government elites at the federal level to tackle Canada's pharmaceutical problem through the adoption of a national pharmacare program. Moreover, self-reinforcing policy feedback effects are also clearly garnered from the development of a national pharmacare plan including, but not limited to, the threat perceived by provincial premiers on the autonomy of existing

provincial pharmacare programs, as well as the private sector's unwillingness to support a national plan.

In this way, using the policy feedback theoretical framework shows that the policy legacies embedded within provincial pharmacare programs have a direct effect on the prospect of a national pharmacare program. Indeed, existing policy legacies and institutional structures at the provincial level have notably shaped the political environment in ways that might affect the adoption of a national pharmacare program by the federal government. For instance, both the public and private sectors in Ontario and Quebec have had considerable influence in the development of their respective pharmacare programs and illustrate the barriers to access that the federal government must consider as they intend to adopt a universal drug program in Canada.

1.2 Contribution to Literature

This thesis contributes to the existing literature on policy feedback theory in two ways. First, I show that the theoretical framework can be applied in the context of federal democratic systems such as Canada to describe the ways in which the federal government must consider the existing policy legacies embedded within subnational governments. Second, following Greif and Laitin (2004) as well as Jacobs and Weaver (2015), I show that policy effects garnered from provincial pharmacare programs, can be simultaneously self-reinforcing and self-undermining. Healthcare reform in Canada, particularly with the current debate on the creation of a national pharmacare plan, exemplifies this point. Forces previously generated endogenously by policies themselves can encourage policy continuity and/or a path-departing change. This is the case in part because policy legacies are complex, and they can simultaneously generate multiple and sometimes contradictory feedback effects over time as they interact with changing economic and political circumstances (Jacobs and Weaver, 2015).

Through a cross-case analysis of existing pharmacare programs in Ontario and Quebec, I have shown that existing institutionalized policy legacies at the provincial level have reshaped the political environment in ways that might affect the adoption of a national pharmacare program by the federal government. In this way, I have argued that the establishment of public policy at the federal level is directly influenced by the policies that exist within these two case studies. Actors in both the public and private sectors in Ontario and Quebec have had considerable influence in the development of their respective pharmacare programs over time, which in turn points to the potential political challenges that the federal government must consider as the national pharmacare program experiences its incremental rollout in the coming years.

1.3 Research Limitations

There are some limitations to this thesis. First, I did not conduct interviews with federal and/or provincial policy actors and interest groups. If I had conducted interviews, my research findings could have been altered by responses from actors who play a central role in the policymaking process in Ontario and Quebec as well as at the federal level. Second, I did not use comprehensive public opinion data. As this thesis employed a qualitative historical institutional approach, I did not believe that conducting public opinion polls would have coherently fit into my framework, as this type of methodology is strongly tied to a quantitative political behaviour approach. Third, this thesis only focused on the policy feedback effects in two Canadian provinces. Put simply, I did not have the space to research policy feedback effects collected from policy legacies in the other provinces and territories. However, I do recognize that doing so could have provided a more comprehensive analysis.

1.4 Recommendations for Policymakers

Pharmacare policy development as experienced within Ontario and Quebec can be best described as a series of compromises in which incremental policy changes, have encouraged further influence from the private sector, deterring the provinces' ability to develop a comprehensive single-payer drug program, and effectively changing the institutional and political landscape for the advent of a national pharmacare program. In turn, the lack of a universal provincial pharmacare plans in both Ontario and Quebec, Canada's two largest provinces, shows the challenges that the federal government will likely face in guaranteeing access to essential mediation to all Canadians through the adoption and implementation of a comprehensive national pharmacare strategy. Considering this reality, I highlight three recommendations for federal policymakers to consider in the adoption of a national pharmacare plan.

First, policy feedback theory suggests that elite attitudes have been shaped by Canada's fragmented system of drug financing. On the one hand, policymakers at the federal level, especially within the Liberal Party of Canada and the New Democratic Party are inclined to adopt a national pharmacare program. On the other hand, elite attitudes within many provincial governments, including Ontario's and Quebec's, point to the fact that they are reluctant to join a national pharmacare program.

In this institutional context shaped by existing policy legacies, federal officials need to seriously consider the close collaboration and extensive negotiations that are required with subnational governments to ensure that the program can function as smoothly as possible. Although it is up to the individual provinces and territories to join a national pharmacare strategy when, and if, they think they are ready to do so, the federal government must remain steadfast in

collaborating with other jurisdictions while putting the fiscal resources and incentives on the table to help bring about a consistent standard of drug coverage across the country.

Second, the fragmentation of pharmacare programs across Canada has reinforced the power of private actors who have a lot to lose in the adoption of a comprehensive national pharmacare program. Policymakers at the federal level must understand the important role that the private sector has played within provincial and territorial drug policies. For example, drug manufacturers and pharmaceutical distributors will have to be directly engaged with the federal government to ensure that the drug supply chain transitions smoothly into a new model run by the newly formed Canadian Drug Agency.

Third, even though the limitations derived from the patchwork of provincial pharmacare programs have caused a recent surge in public support for the adoption of a national pharmacare, federal policymakers need to be cognizant of the temporal constraints that may negatively affect public perceptions if the rollout of a national pharmacare program does not occur in a timely manner. The Liberal Party of Canada has already delayed the rollout of the program a few times, and if the rollout of the program continues to lag, it is possible that the public could lose confidence in its viability. It is therefore essential that the federal government responds promptly to public opinion, which as of now, favours the adoption of a national pharmacare program.

1.5 Agenda for Future Research

This thesis seeks to contribute significant insights into how existing policies can generate strong pressures that may force governments to either maintain or revise these policies over time. Additionally, as exemplified within this thesis, the policy feedback theoretical framework can be useful in illuminating policy outcomes both within and between levels of government.

Considering these remarks, I will now outline three components of an agenda for future research on health policy and policy feedback theory in Canada for other researchers.

First, policy feedback theory could be applied to study the policy effects of other pharmacare programs in Canada. For example, Prince Edward Island recently partnered with the Government of Canada to make further improvements to its drug programs that have made it significantly easier for residents to access drug coverage (Health Canada, 2023). Looking into the policy development of other Canadian provinces or territories could yield important insights into the policy feedback effects of pharmacare programs that exist beyond the case studies of Ontario and Quebec.

Beyond pharmacare, however, for other researchers keen on assessing the intersection of health policy and policy feedback theory, the recent development of dental care in Canada may be of interest. Dental care is a significant aspect of health policy with a longstanding history of provincial arrangements that have acted, until recently, in the absence of a national dental care plan. Although the first phase of the rollout of a national dental care plan has already begun, utilizing policy feedback theory could help illuminate the historical processes that describe the policy effects which may have strengthened or weakened over time.

Finally, health policy in Canada interacts differently with Indigenous peoples. Despite the provisions that exist within provincial, territorial, and federal legislation, Indigenous peoples face disproportionate barriers to accessing healthcare services across the country (Tremblay, 2020). Using a policy feedback theoretical approach could help illuminate the challenges experienced by Indigenous peoples in accessing healthcare services due to the policy effects that have been established by subnational and federal governments over time.

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