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What We Heard: Public engagement on the implementation of national pharmacare in Canada

The Advisory Council on the Implementation of
National Pharmacare



Canada

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

Également disponible en français sous le titre :

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Publication date: June 2019

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Cat.: H22-4/17-2019E-PDF
ISBN: 978-0-660-30713-8
Pub.: 190014

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Executive summary

Canadians, it would seem, want national pharmacare.

That rallying cry was commonly heard among the thousands who participated in an engagement process on the implementation of national pharmacare. Between July and December 2018, over 32,000 individuals and organizations shared their views with the Government of Canada's Advisory Council on the Implementation of National Pharmacare (the Council). The Council gathered feedback through online interactions, letters, written submissions and meetings, roundtables and townhalls held across Canada.

Participants repeatedly said that everyone should be able to access the prescription drugs they need when they are sick. While other issues concerning national pharmacare saw a variety of perspectives, the vast majority of Canadians who participated agreed on the need for pharmacare.

Canada is one of the few developed countries in the world without universal coverage for prescription drugs. Instead, it has a patchwork of many public and private drug plans that leaves many Canadians unable to afford the drugs they need.

That is why the Government of Canada established the Council in Budget 2018 to provide independent advice on how best to put national pharmacare in place for Canadians and their families, employers and governments. Dr. Eric Hoskins, a former Ontario Minister of Health and Long-Term Care, leads the Council, along with six other members. They include: Dr. Nadine Caron, Mr. Vincent Dumez, Ms. Mia Homsy (Vice-Chair), Ms. Camille Orridge, Ms. Diana Whalen and Mr. John Wright.

In March 2019, the Council delivered its interim report on the progress of their work to date to the Ministers of Health and Finance. The [interim report](#) from the Council is available online.

The Council will deliver its final report and recommendations in spring 2019.

The following report is an overview of feedback received from participants in the Council's engagement process. The feedback received reflected the breadth and depth of views and interests of participants, and was not always consistent. The report however, does not present the views of all participants—nor, of course, all Canadians. The views summarized here are those of participants in the engagement process, and should not be construed as representative of the Council's position or views.

How Canadians would create national pharmacare

Purpose of this report

The Government of Canada established the Advisory Council on the Implementation of National Pharmacare (the Council) in Budget 2018 to provide advice on how to implement a national pharmacare program. The Council led a national dialogue on how to implement national pharmacare for Canadians and their families, employers and governments.

The Council's formal public engagement process took place between July and December 2018. To help support focused dialogue between the Council and Canadians, the Government of Canada first published a discussion paper as background. The paper gave an overview of Canada's current system of prescription drug coverage and its challenges. It also identified key objectives and questions to frame the Council's work.

The Council sought feedback through three main methods: online engagement, written submissions, and in-person roundtables and meetings.

By going online to provide their views or sending the Council written submissions, any interested person could share their thoughts on pharmacare and how best to set up a national program. The Council also met face to face with a number of stakeholder communities. These in-person discussions were held to ensure the Council was aware of patients' and stakeholders' perspectives and considerations.

The purpose of this *What We Heard* report is to provide a summary of the feedback the Council received during the public engagement period. The report aims to reflect the some of the key ideas and perspectives that were raised during the entire engagement process. It does not include every comment received nor is it intended to imply consensus on the part of all participants.

The Council is considering this feedback as part of its deliberations for its final report and recommendations, which is to be delivered to ministers in spring 2019. The Council is deeply grateful to every single individual and organization who participated over the course of engagement, lending their time, passion and expertise.

Gaining direction from public insights

In total, over 32,000 individuals and organizations—online, by mail and in person—told the Council how they thought national pharmacare should be achieved.

More than 16,000 individuals and organizations relayed their views on national pharmacare through an online questionnaire, written submissions and discussion forums. Participants largely agreed that everyone should have prescription drug coverage and it should be equal for all Canadians. They also felt that most prescription drugs should be covered, including new innovative drugs. Where participants disagreed was on the topic of how to pay for pharmacare as well as the best model for implementation.

The Council also received over 12,000 campaign letters via email and post. Non-government organizations and health care professional associations organized the bulk of these campaigns.

Most letters called for comprehensive, universal coverage that allows people to access medications based on their need and not their ability to pay. A number of letters also said that pharmacare should be delivered through a single-payer plan, administered by the government. Some writers did not support national pharmacare. They expressed that they wanted to maintain their current prescription drug benefits and were concerned about reductions in their coverage.

The Council travelled to every province and territory to hold in-person discussions through roundtables, meetings and community dialogue sessions.

Consultations were held with provincial and territorial governments, with patients and health care providers, and with experts and key stakeholders from many fields. These fields included health policy, public drug plan policy, finance, business, labour, the pharmaceutical industry, pharmacy, health care organizations, and the insurance and benefits sectors.

The Council also held discussions with Indigenous governments and organizations, including the Assembly of First Nations, Inuit Tapiriit Kanatami and the Métis National Council. In addition, First Nations, Inuit, Métis and representatives of Indigenous governments and organizations were invited to provide written submissions and participate in the in-person discussions.

The participation of patients and caregivers was integral to the Council's engagement. Gaining the insights of patients, family members and caregivers has been shown to transform policy development and implementation, and the Council wanted to make this a key element of its engagement with Canadians. The Council aimed to have patients represent at least one-third of attendees at each in-person regional session. The Council also held two focused roundtables with patients and patient advocates, as well as additional meetings with individuals who identify as uninsured and under-insured to ensure their voices were heard and their advice was given careful consideration.

Main queries and responses

Consultations and discussions probed these main questions:

- **Who should be covered?**
- **How should pharmacare be delivered?**
- **Which prescription drugs should be covered?**
- **How should national pharmacare be paid for?**

Passion and insights surfaced with each meeting and session, though often there was no clear consensus on many points and significant variation in the views expressed.

Despite this diversity, there were common threads that continued to come up across the country. The Council was left with a clear message that the current system of prescription drug coverage in Canada is not sustainable over the long term and leaves too many Canadians behind, particularly vulnerable populations.

These common threads included the following.

- National pharmacare should cover all Canadians, giving them the same coverage across all provinces and territories. Work status, age, province or territory of residence, or ability to pay should not determine drug coverage.
- The criteria for listing prescription drugs on a national formulary (a list of drugs whose costs can be reimbursed through a drug insurance plan) should include safety, clinical effectiveness and cost effectiveness. A politically neutral body of experts should manage the formulary in a fiscally responsible and sustainable way.
- While there was no clear consensus on cost-sharing mechanisms, for example, copayments, many indicated that their use could pose a barrier to access.

Who should be covered?

Key points

- Make national pharmacare available to everyone in Canada, with the same coverage across provinces and territories ensuring coverage for those who are uninsured and underinsured.
- Make sure no one loses existing coverage or is worse off as a result of a national pharmacare program.

The current situation

Most other countries with a universal health care system include prescription medication coverage.

But in Canada, things are different. Medicare, Canada's publicly funded health care system for doctor and hospital services, only covers the cost of prescription drugs given to patients in hospitals. For drugs that doctors or specialists prescribe outside hospitals, coverage varies across the country, with more than 100 public and 100,000 private insurance plans having been created to serve the needs of Canadians. Even Canadians with prescription drug coverage can face patient cost-sharing mechanisms in the form of premiums, deductibles, co-payments and co-insurance that can make affording prescription drugs a challenge.

Since Medicare began in the 1960s, it has been hoped that the program would eventually include prescription drug coverage. But for a number of reasons, this never happened. That is why every major study of Canada's health care system in the past 50 years has singled out the lack of public coverage of prescription drugs as a major gap.

Drug Coverage Terms

Deductible: This is the dollar amount that an individual must pay out of pocket, usually annually, on prescription drugs before the drug plan will begin to pay.

Copayments: After the deductible limit has been reached, this is the amount paid out-of-pocket by an individual each time a prescription is filled, with the remainder of the cost paid by the drug plan. This can either be a percentage amount (e.g., 20 per cent of the prescription cost) or a fixed payment per prescription (for example, \$5 per prescription).

Premium: This is a fixed amount (often paid annually) that an individual must pay to enrol in a drug insurance plan. This amount is payable whether or not the individual uses their benefits under the plan.

Plan maximum: This is the maximum amount a drug plan will contribute to an individual's prescription drug costs; this can be either an annual maximum or a lifetime maximum.

In the absence of a universal system of prescription drug coverage, Canada has evolved into a mixed system. Public and private drug plans fall into the following categories.

- **Private plans funded by employers:** For many working Canadians and their dependents, these plans cover much of their prescription drug expenses.
- **Public plans run by provincial and territorial governments:** These plans generally provide at least partial coverage for seniors, people receiving social assistance and patients with certain diseases. Many provinces also offer some form of drug coverage for residents who have high drug costs relative to their income. These are often referred to as catastrophic drug plans.
- **Public plans run by the Government of Canada:** These plans cover distinct populations, among them First Nations and Inuit, members of the military, veterans, federal inmates and some refugees.
- **Private plans funded by individuals:** Canadians who are self-employed, employed part-time or have low-paying or precarious work where there is no employer plan may choose to purchase a plan.

Access to public drug coverage varies greatly across Canada's provinces and territories, which administer health care in their jurisdictions. Two patients with the same need, living in different parts of the country, could have different prescription drug coverage. They may also pay different out-of-pocket costs.

Some public drug plans are available to all residents of a province or territory. Others are geared to certain groups, based on factors such as income, demographics, disease or drug costs. Some jurisdictions have only a handful of drug plans while others have close to 20 or more.

Despite the public and private insurance plans offering coverage in Canada, there are still gaps. Approximately 20 per cent of Canadians are uninsured or underinsured for prescription drugs, meaning that they have inadequate coverage for their needs. Some public drug plans cover all prescription drug costs for individuals, usually for those with little income. But often, an eligible average-income household has to pay several thousand dollars out of pocket annually before the public plan starts covering costs. People covered by private drug plans can also face high copayments that can deter them from filling their prescriptions. In 2015, the Angus Reid Institute found more than one in five Canadians reported that they, or someone in their household, could not take their medications as prescribed due to cost.

As well, some Canadians, such as low-income individuals, LGBTQ+ and other individuals, may not be able to navigate the health care system to take advantage of the plans available.

What people want

Almost everyone that the Council heard from felt that national pharmacare should be available to all Canadians. And that all Canadians, across all provinces and territories, should have the same coverage. Their work status, age, province or territory of residence or ability to pay should make no difference.

The pain of being under-insured

Affording prescribed medicine can be challenging for many, with more than 20 per cent of Canadians reporting that they cannot afford to pay for their medication. Some participants called user fees, like deductibles and copayments, a “tax on the sick and poor” — especially for people suffering multiple illnesses. Consider the case of a person with limited disposable household income and, say, six prescriptions that each needs to be refilled each month. This out of pocket cost can be sizable. It could mean having to sacrifice paying for a basic need, like heating or nutritious food.

Several participants said prescription drug costs paid out of pocket by patients should be the same across Canada as well. Some people said that the national pharmacare program should be available to those with a health insurance card.

One point mentioned repeatedly was that national pharmacare must improve coverage for Canadians. Nobody should lose the level of coverage they have now, or be worse off as a result of the program.

A number of people stressed that national pharmacare must cover marginalized segments of society. The program’s first focus should be to serve uninsured and under-insured individuals, they said.

There was debate about what criteria should be used to register for the program. Should the program be at no cost to the patient? Or should there be an amount of money paid, a deductible, based on a person’s income (called “income testing”) before their coverage starts?

Some participants noted that a challenge with income testing is that people across Canada may earn the same amount of money each year but face different expenses. These varying expenses depend on people’s personal situations or the cost of living in their area. A person’s income may change year to year, also.

Additionally, some participants pointed out that while income testing would help uninsured people get prescription drug coverage, it could also be a barrier to care. They would

still have to pay cost-sharing fees like deductibles, premiums and/or copayments and there may be additional administrative barriers to access coverage.

Suggestions to the Council

- ✓ Make national pharmacare available to everyone in Canada, with the same terms of coverage across provinces and territories.
- ✓ Ensure that national pharmacare improves coverage for Canadians and doesn’t reduce the level of their current coverage available through public and private drug plans.
- ✓ Set national standards for access, no matter how the program is delivered.
- ✓ Make sure that marginalized people get reliable coverage.

How should national pharmacare be delivered?

Key points

- There was no consensus on whether a fully public or a mixed public-private system was the best model.
- Most agreed that a national pharmacare program should be designed to be simple for patients and health care providers to use.

The current situation

As discussed earlier, Canada currently delivers pharmacare through a mixed public-private system. This system is seen to have both positive and negative characteristics.

Public and private drug plans throughout Canada have voluntary enrolment, except in Quebec. There, it is mandatory for residents to have prescription drug coverage, through a private plan or the public plan.

Private plans often cover drugs that may not be covered under public plans, although some private plans are shifting to restrict the list of drugs covered. Participants often described it as easier for people to get prescription drugs through private plans because there are fewer restrictions on how the drug is to be used.

Some participants said that not all health care providers and pharmacists are familiar with their public drug plan's formulary. Clinicians sometime prescribe drugs that the drug plan doesn't cover. This forces patients to go see their health care provider a second time to get a prescription that the drug plan will cover. This after having made a trip to get the first prescription filled. Some patients, especially seniors and elders, may not bother going back a second time.

Many people living in remote communities pointed out other problems for their populations. They felt that drug plans do not take into account logistical and access challenges that their communities face. Due to weather, it can sometimes take weeks for medication to arrive by plane, and many people in remote communities don't have easy access to pharmacies. Transportation to and from the health care provider and pharmacy can be time-consuming and costly.

What people want

While the need for a national pharmacare plan was widely supported by participants, there was much debate over what form the program should take, with no clear consensus. Which is best, people queried—a single-payer public system in which government pays? Or a mixed public-private system in which the public and private sectors both continue to operate? Despite the debate over the model itself, there was agreement that whichever model is chosen, decision making should not be politically influenced and the program should be sustainable over time.

Some participants also questioned whether the Government of Canada would be able to deliver a national program on its own. Instead, they asked, should provincial and territorial governments retain the ability to deliver services, but through a national program funded by the Government of Canada?

There was also debate, without consensus, about whether national pharmacare should be part of the *Canada Health Act*. This is the federal legislation that sets and administers national standards for Canada's health care system.

Some people also stressed that a national pharmacare program should not be one size fits all, and that it should allow for choice of First Nations, Inuit and Métis to participate.

Single-payer public system vs. mixed public-private system

A single-payer public plan: A number of people said that a single-payer public system would ultimately give Canadians more uniform coverage across the country and cost less. It was assumed that it would achieve lower prices on drugs through stronger negotiating power and lower administrative costs.

The assumed cost-savings of a national program were regularly debated, however. Some pointed out that the pan-Canadian Pharmaceutical Alliance (pCPA)—an alliance of federal, provincial and territorial drug plans—has already significantly reduced prices. The pCPA conducts negotiations on behalf of federal, provincial and territorial governments on brand and generic drugs.

In addition, a single-payer public system was seen as more equitable and in line with Canada's medicare system. Some participants also said that a single-payer plan would be simpler for patients to understand and easier to keep consistent across provinces and territories.

However, some participants expressed concerns that a single-payer system would take a long time to set up and would significantly disrupt private insurance coverage. As well, some participants said that public plans don't always cover all available drugs for chronic conditions and rare diseases, which private plans tend to cover. They added that moving to a fully public plan might mean people with chronic conditions and rare diseases end up losing access to their current medications.

A mixed public-private system: A number of participants felt that the current mixed public-private system works well for most Canadians. They suggested that a public-private system would have the financial strength to provide more choice to patients—with private plans supplementing the public program—and be sustainable. Some employers indicated that this system would be valuable, as private insurance benefits are a tool in attracting new staff. However, other participants stressed that employers may want relief from the cost of providing employee drug benefits as part of their health plans.

Some participants thought that having a system where government would pay for costs up to a certain amount (acting as first payer) and private plans would cover any expenses above that limit (acting as second payer) would be good. Others suggested that the government should provide relief to private drug plans by assuming responsibility for high-cost drugs.

Other participants suggested that Canada start with a public-private system and eventually move to a fully public system.

Participants shared anecdotally that, over time, there is a risk in a mixed system that private plan prescription drug costs would fall onto public plans. Therefore, if national pharmacare is delivered through a mixed system, it should be designed so that the private system doesn't offload costs onto the public system. Otherwise, the growth of public sector costs could become unmanageable as more high-cost drugs arrive on the market.

However, some participants expressed concern that a public-private system, like a fully public system, could be disruptive to the health insurance sector.

Enablers of a national pharmacare plan

National computer systems for prescribing and tracking drugs:

Running a cross-Canada information technology (IT) system for prescription drug data is another challenge that participants raised. They felt that data is poorly managed on a national level now. The format of data differs across provincial and territorial systems and electronic medical records, making it hard to link information across Canada.

Some provincial and territorial governments have high-functioning drug IT systems. Others have older systems that could be improved. Still others, faced with limited resources, would have difficulty meeting the IT requirements that a new national pharmacare program may need. Investing in IT systems is necessary, participants said.

Ultimately, more effective IT systems can help health care professionals and others to better understand prescription drug use and improve patient safety.

Make national pharmacare easy to use, culturally appropriate: Participants expressed that no matter how national pharmacare is delivered, the support of provincial and territorial governments is critical. Also, any model chosen should be simple to navigate for both patients and health care providers. Current insurance plans require that a lot of paperwork be filled out, some participants said. If the administrative barrier was lessened, they noted, health care providers could then spend more of their time caring for patients.

Altering your life to secure prescription drugs

Since publicly offered pharmacare plans vary from one jurisdiction to the next across Canada, there are different terms and processes to determine eligibility. Individuals spoke of the burden to access coverage, sometimes having to alter their lives to get the drugs they need. Some went so far as to get a divorce to reduce their total family income and deductibles. Individuals also spoke of moving back in with family members to get better coverage, changing careers to access benefits or quitting their jobs to avail of better coverage through social assistance.

Culturally appropriate and culturally competent care is necessary, too, said some participants. This refers to health care services that are sensitive to the social, cultural and linguistic needs of an individual. All patients have unique experiences in the health care system and national pharmacare must consider this. It must recognize that cultural background will influence illness-related behaviour. So, too, will previous health care experiences, levels of education, degree of acculturation, language skills and socio-economic status.

Discussions with Indigenous participants reiterated that retaining choice in their pharmacare services is important and that further engagement will be required. Participants also discussed challenges Indigenous people experience in accessing medication.

Finally, some participants underscored that all diseases should be treated equitably under national pharmacare. They believed that doing so would reduce the need for specialized public plans for rare diseases.

Suggestions to the Council

- ✓ Make the program simple for patients and health care providers to navigate and access, perhaps using something like a health card.
- ✓ Implement national pharmacare step by step, and draft a plan to improve long-term sustainability.
- ✓ Ensure that a national pharmacare program is sustainable and not subject to political changes.
- ✓ Educate patients, the public and health care providers on the appropriate prescribing and use of medications.
- ✓ Invest in IT systems that are connected and make it easier to prescribe and track drugs.

Which prescription drugs should be covered?

Key points

- Ensure that a national formulary lists only drugs that evidence has shown to be safe, are proven to work well, and are good value for money.
- Include medical devices, diagnostic therapies and other equipment and services that people need, along with their drugs, to get better.
- Evaluate rare disease medications under a different process.

The current situation

In Canada, public and private drug plans determine which drugs they will include in their respective formularies.

Any drug sold in Canada must first be assessed by Health Canada to demonstrate that it is safe to use and works as intended. After this, public and private drug plans take different approaches to deciding which drugs to include in their formulary.

How formularies for public drug plans are created: Following Health Canada’s assessment, Canada’s public drug plans ask one of Canada’s two health technology assessment agencies—either the Canadian Agency for Drugs and Technologies in Health (CADTH) or the Institut national d’excellence en santé et en services sociaux (INESSS)—to study whether a new medicine is clinically effective and offers value for money relative to other treatment options.

Recommendations by these organizations are then used to inform decision making and negotiations by the pCPA on behalf of participating jurisdictions. Once negotiations have concluded, each participating provincial and territorial drug plan is responsible for listing products on its formulary.

How formularies for private drug plans are created: Following Health Canada’s assessment of a drug, most private drug plans immediately list that drug on an “open” formulary. Such a formulary offers plan members a greater choice in drugs. The employers who sponsor the majority of Canada’s private drug benefit plans use these plans to attract and retain employees and have typically offered a wide choice of drugs to their plan members. However, as more and more costly drugs enter the market, some private drug plans are moving to more actively manage their formularies to help contain costs.

What people want

Should there be a national formulary?

The idea of creating a national formulary drew a variety of opinions during the Council’s consultations. Some participants favoured a national formulary in addition to provincial and territorial formularies. Some suggested that if a national formulary is comprehensive and portable—meaning that the same drugs are covered across all provinces and territories—then provincial and territorial governments may not need to keep their own formularies.

Many participants agreed, though, that any formulary should list only drugs that evidence has shown to be safe, are proven to work well and are good value for money. A number of people said that the process for adding or removing drugs should be based on evidence, and should be neutral and transparent. The process should be simple and consistent across provinces and territories—or at least consistent with limited flexibility.

Many felt that Canada should harmonize federal regulatory processes, and streamline provincial and territorial processes, in order to shorten delays. This would reduce the time needed for listing drugs on a national formulary. As well, the time from approval of a new prescription drug until it is in the hands of patients must be sped up, some participants said.

Numerous participants said that a Canada-wide formulary was the only way to make sure national pharmacare was sustainable, consistent and cost-effective. Others felt a national formulary would be too restrictive.

Some suggested that provincial and territorial formularies should be required to align their formularies to the national formulary. This way, provincial and territorial governments would be protected from political pressure urging them to add or remove certain drugs to or from their lists. One way to make sure provincial and territorial governments follow the drug recommendations would be to link their actions to federal cost-sharing, suggested some participants.

What should a national formulary include?

A few participants pushed for a fully open formulary where Canadians could get any Health Canada–approved medication they need. Others thought that this was impractical, given that governments must balance cost and patient choice on a public formulary. Participants were not in agreement over what a national formulary should include but they seemed to agree that any formulary should be comprehensive and evidence-based.

Suggestions from participants on how to build this formulary varied, including starting with a formulary that, while limited, offers choices to patients and, gradually, adding drugs to it. Some people suggested that a formulary begin with the World Health Organization (WHO) Essential Medicines list as a base, for example. These are roughly 400 medicines, deemed as essential, that meet a population’s top health care needs. Participants indicated that drugs from provincial formularies could be added to the WHO list.

Some participants suggested using hospital formularies as a starting point. They suggested that having the same drug list as a hospital would smooth the transition of patients back into communities and life outside hospitals.

Generic and biosimilar drugs

Some participants said that a national formulary should favour generic and biosimilar drugs.

Patented drugs are usually called brand drugs or “innovative medicines.” When a company creates a new drug, it registers for a patent with the government. The patent gives the company the right to be the only one to market that drug and sell it under a brand name. The generic equivalent can enter the market only after the brand drug’s patent expires.

Generic drugs are the equivalent of an already marketed brand-name drug in safety, quality, performance, dosage form, strength, route of administration and intended use. Generic drugs are less expensive than the brand-name products. Because of that, different drug plans in Canada encourage the use of generic drugs. However, many drugs in Canada are not yet available in generic form.

Many of the new drugs entering the market today are biologics, which are made from living cells or organisms using biotechnology. This makes them harder to develop and manufacture than traditional chemical drugs and also more expensive. A biosimilar is a biologic drug demonstrated to be similar to a brand-name drug already authorized for sale (known as the reference biologic drug). A biosimilar enters the Canadian market after the patent for the original biologic product has expired.

A number of people agreed that a national pharmacare program should take steps to increase the use of generic and biosimilar drugs to help make Canada’s public drug programs more sustainable. They suggested that one way to do that would be to use incentives and other formulary management policies—like covering the cost of copayments for beneficiaries if they take a generic drug equivalent or generic substitution or having a higher copayment for a branded drug.

Many provinces have policies about generic drugs. For example, pharmacies may be required to substitute generic drugs for the prescribed brand product under both private and public plans. Details from participants about how widely generic drugs are used across private plans varied.

However, some participants were opposed to increasing the use of generic and biosimilar drugs for various reasons.

Some suggested that generic drugs are not as effective and therefore patients still would need to access the brand drug. They said that being forced to accept cheaper generic drugs over brand-name drugs that their health care providers had prescribed felt like the “good” drugs were being withheld. Individuals raised the issue that in order to get that more expensive brand drug, their insurance plan forces them to pay the difference in price.

Participants said that governments could also educate Canadians and prescribers about generic drugs and, at the same time, dispel some misconceptions through marketing campaigns.

Medical treatment today depends on your address

Access to prescription medications on public plans varies tremendously across provinces and territories. If you're a patient in need of prescription medications, your home address can determine whether or not you are eligible and have coverage for your prescription drug costs under the public plan. Participants described cases where patients absorb huge out-of-pocket expenses because their prescription drugs are not covered by public plans. Or, they take the drastic step of moving to another province or territory that has better drug coverage. A patient from one province might leave a job, family and treasured memories to move many kilometres to another province, for the sake of better terms of coverage.

Include more than drugs, make exceptions

Many participants said medical devices such as insulin pumps and blood glucose test strips should also be part of a national formulary. They pointed out that drugs alone can't help patients if they don't have the accompanying medical devices and supplies they need to use the drugs. Other people wanted a formulary to include diagnostic therapies and tests like genome testing.

In terms of preventive strategies that could lead to better health, various participants urged that a national formulary also include preventive medication and healthy living services. Some participants also urged that alternative and traditional medicines be included.

A national formulary must be able to adapt quickly, participants noted. It must also be able to make exceptions on a case-by-case basis to approve drugs that aren't listed.

There could be many reasons for making an exception to the rule. Patients may not respond well to certain medications listed on the formulary. Due to interactions between drugs, some patients already taking other medications might need other drug options. As well, drugs for rare diseases may not be listed on a national formulary.

Participants said that doctors and other health care professionals who prescribe for patients need to be educated on cost-effective drugs and when to make exceptions.

Managing the formulary

A number of participants called for a new committee of experts to decide which drugs and products should be part of a national formulary. It was suggested that doctors, nurses, patients, patient groups, pharmacists, academics, labour leaders and technology experts could sit on this body.

This committee should be non-political, participants stressed. Nobody from political or private sectors should be able to influence the committee's decisions. Currently, it's hard for provincial and territorial drug plans to stand up to such political pressure. The committee would also be able to better manage pressure on the drugs it chooses for a formulary.

Participants wanted clear and structured guidelines that could help committee members make decisions. They should add or remove drugs quickly when the evidence calls for that, with decisions based on health outcomes and cost effectiveness. The committee should be transparent with the public on how it made decisions to list or de-list certain drugs.

There would also need to be a guarantee that this national committee would get adequate, sustainable and predictable federal funding year after year.

Other people, though, felt that an existing organization like CADTH could manage a national formulary if it was resourced differently and strengthened.

Suggestions to the Council

- ✓ Have a strengthened CADTH or a neutral interdisciplinary committee of experts create and manage a national formulary.
- ✓ Ensure that a national formulary includes items that improve health outcomes for Canadians—this includes generic and brand drugs, and new high-cost drugs such as biologic therapies.
- ✓ Use formulary management policies such as mandatory substitution and public education campaigns to encourage drug plan beneficiaries to use generic and biosimilar drugs.
- ✓ Include medical devices and supplies that are needed to use prescription drugs in a national formulary.
- ✓ Ensure there is patient and prescriber choice in the national formulary.
- ✓ Design a national pharmacare program to accommodate new drugs being developed, such as those for rare diseases.
- ✓ Improve and streamline the drug approval process to make it less cumbersome (this includes accessing drugs not listed on a formulary or where no alternatives are listed).

How should national pharmacare be paid for?

Key points

- Make sure that federal funding for national pharmacare is sufficient, predictable and long term.
- Consider raising revenue through income or corporate tax increases.
- Ensure that the use of patient cost-sharing mechanisms like copayments do not pose any barriers to access.

The current situation

Canada spends \$34 billion annually on prescription drugs, according to a 2017 Canadian Institute for Health Information report. Of that amount:

- public drug plans pay for \$14.4 billion (43 %)
- private insurance (mostly employer-sponsored plans) pays for \$12.3 billion (36 %)
- individual Canadians pay for \$7.4 billion (21%)
 - individuals pay out-of-pocket payments such as copayments, deductibles and premiums.

Through the Patented Medicine Prices Review Board (PMPRB), the Government of Canada regulates the maximum allowable price of patented drugs. Still, prescription drug prices in Canada are among the highest in the world.

As well, drug spending in Canada has grown a lot over the past few decades. This is due to an aging population and more high-cost therapies like biologic drugs entering the market. A 2015 survey of 29 member countries of the Organisation for Economic Co-operation and Development found that Canada was among the top three countries for drug spending per capita. Only the United States and Switzerland spent more.

The price Canadians pay for their drugs is also affected by pharmacists' dispensing fees and markups, which vary widely across provinces and territories.

The amount of money being spent now on high-cost drugs is sizable, too, even though patients for such drugs are comparatively few in number. The PMPRB reports that in 2017, while less than 1 per cent of Canadians took drugs costing \$10,000 per year or more, they accounted for just over 40 per cent of patented medicine sales.

The patchwork of public and private prescription drug coverage in Canada was not designed to handle the increasingly expensive drugs entering the market. Canadians themselves pay for these high and rising drug costs. They pay through out-of-pocket expenses, taxes or costs that their employers pass on.

What people want

Lower drug prices that are the same across Canada

Participants generally agreed that prices of drug products need to be lower to make private and public drug plans more affordable and sustainable.

Participants from the brand drugs industry argued that Canada is able to attract pharmaceutical research and development (R&D) today precisely because of higher brand drug prices. They said that countries with higher brand drug prices and good market access are more attractive places for companies to invest in R&D and launch new drugs.

Concerns were raised by some participants regarding the impact of driving prescription drug prices down. These included limiting patient access to new medicines and concern regarding drug shortages.

Many participants were worried about the rising costs of prescription drugs, too, as the costs are becoming unsustainable for both public and private plans. Private insurance companies have asked to be part of the pCPA, allowing them to benefit from joint negotiations with public plans. However, innovative pharmaceutical manufacturers said that this could have unintended consequences on the prices negotiated nationally; they indicated that discounts to public plans could be reduced.

Another theme that participants raised was that national pharmacare should make the costs that the patient pays at the pharmacy the same across Canada. In the North, for example, prescription drugs can cost patients almost three times as much as in southern Canada. There, high drug costs are heavily affected by pharmacy markups and fees.

Sufficient, reliable funding a must

Federal spending, participants stressed, must be sufficient, predictable and long term. Provincial and territorial governments could not support a universal single-payer national pharmacare system without a strong federal partner.

Participants also expressed that federal funding must take into account the size of provincial and territorial populations and their demographics—specifically, higher rates of seniors. Even in a public-private system where the public plan pays for costs up to a certain baseline and private plans cover expenses above that limit, there are restrictions. Provinces or territories with more senior citizens, for example, would scarcely be able to afford to go beyond what they currently offer.

Some participants felt that Quebec's universal public-private model with its mandatory coverage should be considered. Others from the business sector were less enthusiastic. They said that a mandatory model would boost costs for employers and limit their flexibility.

Annual drug bills that cost more than a house

A key reason that prescription drug costs are increasing is the flood of new high-cost specialty drugs on the market. It's a trend that government participants highlighted as a major concern for them. These products include biologics, expensive drugs for rare diseases and cancer drugs. More and more of these high-cost specialty drugs are being used outside hospitals to treat complex chronic conditions, such as rheumatoid arthritis. According to *Pharmacare Now*, an April 2018 report from the House of Commons Standing Committee on Health, these new drugs often help patients who had no other treatment options. Because of that unique situation, these drugs can command high prices—as high as \$500,000 and \$700,000 per year per patient.

Possible ways to pay for national pharmacare

Participants suggested a variety of ways to pay for national pharmacare. However, there was no consensus on the subject.

Taxes: A number of participants felt an increase in personal income tax could be one of the fairest ways to raise funds. Some debated whether Canadians would accept a raise in income tax. Others pointed out that it is important to tell taxpayers why the tax increase is needed and how national pharmacare benefits communities in the long term. Other participants were concerned, though, indicating that levels of taxation in some provinces were already very high.

Some suggested another possibility would be to boost corporate taxes. Others, however, thought this might be risky for small businesses with their tight budgets. Some participants also worried that higher corporate taxes would make Canada less attractive to foreign investment.

Participants suggested that if national pharmacare was delivered through a fully public plan, monies normally paid for private plans could be re-directed. An income tax hike could be equal to the amount an employee would normally pay for his or her deductible in an employer-funded drug plan. A corporate tax hike, or a payroll tax, could be a net tax amount equal to an employer's private insurance payments.

Some participants felt that employers might not be happy with a fully public pharmacare system. Employers would lose the use of private drug plans to attract new staff, yet may still be forced to pay more in tax.

Another suggestion was to raise the Goods and Services Tax (GST) or Harmonized Sales Tax (HST). Some participants suggested spreading increases across income tax, corporate tax and GST/HST.

But a number of people preferred hikes on income or corporate taxes rather than on GST/HST. A GST/HST increase would increase the cost of basic necessities. That would hurt low-income residents the most.

User fees: Participants had mixed feelings about making patients pay for premiums, deductibles and copayments on their prescription drugs. It was acknowledged that costs can be a barrier to people getting the medical care they need. This becomes even more difficult when a patient with different ailments must fill several prescriptions. Some thought that user fees should be avoided because poor sick people will be less likely to get the medical help they need if cost is an added barrier. The argument was made that educating patients about drug costs and funding sources could work better than user fees to discourage prescription drug misuse.

Other participants felt, however, that when individuals have to shoulder some of the cost of their medication, they will be more likely to take their drugs. These participants recommended the use of modest cost-sharing mechanisms. Making sure that user fees are income-tested could be another option, suggested some.

Quite a few participants said they would prefer an increase in income or corporate tax over user fees. And if user fees like copayments had to be put in place, people should be allowed to deduct the cost from their taxes. Also, a few participants suggested that the money that copayments bring in could be less than the cost to administer copayments.

Smarter buying and operating strategies: Several participants mentioned key strategies to save dollars. One is to get lower prices from manufacturers on prescription drugs by having a single customer negotiate prices on behalf of a group of buyers. This tactic is popularly referred to as “bulk pricing” or “bulk buying.”

Eliminating separate product listing agreements between provincial and territorial governments and prescription drug manufacturers after reduced prices have been collectively negotiated through the pCPA would save time and money. This would result in one product listing agreement for all provinces and territories.

The second strategy is to encourage greater use of generic and biosimilar products, which are less expensive than brand drugs and biologics. The increased use of generics and biosimilars could bring savings to the health care system.

Even small changes can make a difference. An example given was allowing patients with chronic conditions to fill prescriptions for a longer period of time. This cuts down on repeated trips to the drug store and repeated pharmacy services costs. Doctors and others who prescribe drugs should be made aware of costs to help add to Canada-wide savings. Others noted that better managing pharmacy dispensing fees and markups overall could lead to savings as well.

Savings within Canada’s health care and social systems: Some participants voiced the opinion that adopting national pharmacare could lead to savings in Canada’s health care and social systems that could help pay for a new national pharmacare program. Some participants cautioned that any savings recouped will not be immediate, though.

Some participants also felt that national pharmacare could lead to fewer social insurance claims. In some cases, people with poor drug coverage at work or none at all go on social assistance to get better coverage. Some participants argued that if there was a national pharmacare program available to all, those people currently staying on social assistance to access drug coverage would be more likely to try to return to work. This could boost output throughout workplaces and shrink social assistance costs.

Lastly, participants voiced that a national pharmacare system should foster healthier citizens. Fewer sick people being hospitalized or seen in emergency rooms will mean a drop in hospital expenses and, again, more productive workplaces, they said. Providing education on alternative therapies, healthy living, disease prevention and early treatment would also help lower health care costs. Participants also noted that no matter how it is financed, that the Government of Canada should communicate the financial details and health benefits of a national pharmacare program widely.

Suggestions to the Council

- ✓ Raise funds to pay for national pharmacare through one or more of these tools:
 - taxes on individuals and businesses, such as income tax, corporate tax, payroll tax, or possibly GST/HST
 - consider user fees that individuals pay, such as deductibles, copayments and annual premiums
 - smarter buying and operating strategies, like bulk pricing, greater use of generic and biosimilar products and efficient IT systems
 - re-investment of savings in health care and social systems resulting from national pharmacare
- ✓ Ensure that national pharmacare truly delivers value for money so that provinces and territories are not saddled with extra costs.
- ✓ Make the price of prescription drugs the same across Canada.
- ✓ Put reasonable limits on deductibles, copayments and other out-of-pocket expenses so that people can afford prescription drugs.

Conclusion and next steps

The insights of over 32,000 diverse stakeholders on how best to put national pharmacare in place have helped the Council enormously.

It is essential that Canadians have a voice in shaping the creation of a national pharmacare program. By shining the spotlight on a broad range of perspectives, this feedback allows the Council to understand the complexities of the existing landscape as it works to build consensus on a path forward.

In addition to these insights, the Council has also been conducting a fiscal, economic and social assessment of domestic and international models relating to pharmacare.

As well, Health Canada and Finance Canada have been providing policy support to the Council. This includes the development of a costing model on potential pharmacare program design.

All three elements—stakeholder insights, assessments of other pharmacare models and an accurate costing model—will form part of the Council’s report to the federal Ministers of Health and Finance.

In March 2019, the Council provided an interim report to the Ministers of Health and Finance. The [interim report](#) from the Council is available online.

The Council will deliver its final report and recommendations to the Government of Canada on the implementation of a national pharmacare program in spring 2019. The report will provide a full and clear analysis of costing, governance and implementation issues regarding national pharmacare.

Acknowledgement

The Advisory Council on the Implementation of National Pharmacare is deeply grateful to each individual and every organization who provided their time, advice and insights on how to create national pharmacare in Canada.

Many took part in the national engagement process, over 32,000 individuals and organizations participated – online, by mail and in person. The Council travelled to each province and territory and held in-person discussions through roundtables, meetings and community dialogue sessions.

The following organizations attended various meetings across Canada in 2018 and/or made a submission to the Council. For privacy reasons, the list does not include the names of over 100 individuals and patients who provided feedback through meetings. This list also does not include organizations who were invited but unable to attend the regional roundtables, individual members of the public who attended and participated in the community town halls, made written submissions, or the names of individuals who attended the Council's meetings with government, industry and Indigenous groups.

Participants

AbbVie Corporation
Accompass
Acho Dene Koe First Nation
Action Canada for Sexual Health and Rights
Actuariat-conseil Inc
Alberta Blue Cross
Alberta College of Pharmacy
Alberta Dental Association and College
Alberta Federation of Labour
Alberta Federation of Union Retirees
Alberta First Nations Health Co-Management Subcommittee
Alberta Health Services
Alberta Medical Association
Alberta Pharmacists' Association
Alberta School Employee Benefit Plan
Alberta Union of Provincial Employees
Alberta, Ministry of Health
Alliance for Healthier Communities
ALS Society of Canada
Alzheimer Society of Prince Edward Island
Amgen
Anishinaabeg of Kabapikotawangag Resource Council
Apotex
ArcelorMittal Dofasco G.P.
Archway Insurance
Armco Capital
Arthritis Society
Arthur J. Gallagher & Co.
Assembly of First Nations Chiefs Committee on Health

Association des pharmaciens des établissements de santé du Québec
Association of Family Health Teams of Ontario
Association of Iroquois and Allied Indians
Association of Local Public Health Agencies
Association of Registered Nurses of British Columbia
Association of Registered Nurses of Manitoba
Association of Registered Nurses of Newfoundland and Labrador
Association of Yukon Communities
Association québécoise des pharmaciens propriétaires
Asthma Canada
AstraZeneca Canada Inc.
Atlantic First Nations Health Partnership
Auto Sector Retiree Health Care Trust
Avenue Solutions
Bayshore Specialty Rx
Bell Canada
Benecaid
Benefits by Design
Best Medicines Coalition
Better Pharmacare Coalition
Bigstone Health Commission
Biogen
BioScript Solutions
Biosimilars Canada
BIOTECanada
Bison Transport
Blood Ties
BluePeak Advisors
Boehringer Ingelheim Limited
Bowman's Pharmasave
BoyneClarke LLP
Bristol-Myers Squibb Canada Co.
British Columbia Cancer Agency
British Columbia Child and Youth Advocacy Coalition
British Columbia Dental Association
British Columbia Federation of Labour
British Columbia Government and Service Employees' Union
British Columbia Health Coalition
British Columbia Schizophrenia Society
British Columbia, Ministry of Health
Business Council of Canada
Calgary Co-operative Association Limited
Canada Health Infoway
Canadian Agency for Drugs and Technologies in Health
Canadian Arthritis Patient Alliance
Canadian Association for Pharmacy Distribution Management
Canadian Association for Retired Persons
Canadian Association of Community Health Centers
Canadian Association of Pharmacy Students and Interns

Canadian Association of Social Workers
Canadian Blood Services
Canadian Breast Cancer Network
Canadian Cancer Society
Canadian Cancer Survivor Network
Canadian Chamber of Commerce
Canadian Chiropractic Association
Canadian Council for Rehabilitation and Work
Canadian Council of the Blind
Canadian Dental Association
Canadian Diabetes Association
Canadian Doctors for Medicare
Canadian Epilepsy Alliance
Canadian Fabry Association
Canadian Federation of Independent Business
Canadian Federation of Medical Students
Canadian Federation of Nurses Unions
Canadian Foundation for Healthcare Improvement
Canadian Generic Pharmaceutical Association
Canadian Health Policy Institute
Canadian Hemophilia Society
Canadian Imperial Bank of Commerce
Canadian Institute for Health Information
Canadian Institute of Actuaries
Canadian Labour Congress
Canadian Life and Health Insurance Association
Canadian Lung Association
Canadian Medical Association
Canadian Mental Health Association
Canadian Mental Health Association - National Council of People with Lived Experience
Canadian National Pensioners Association
Canadian Nurses Association
Canadian Organization for Rare Disorders
Canadian Paediatric Society
Canadian Patient Safety Institute
Canadian Pharmacists Association
Canadian PKU and Allied Disorders
Canadian Positive People Network
Canadian Public Health Association
Canadian Skin Patient Alliance
Canadian Society of Hospital Pharmacists
Canadian Spondylitis Association
Canadian Treatment Action Council
Canadian Union of Public Employees
Canadians for Equitable Access to Depression Medication
Cancer Care Ontario
CanCertainty
Cardiac Health Foundation
Cardiac Transplant Clinic

Cargill Limited
Carleton University, School of Public Policy and Administration
Catalyst Health Solutions
Centre for Drug Research and Development
Centre for Sexuality
Centre Universitaire de Santé McGill
CGI Inc.
Chiefs of Ontario Health Coordination Unit
Children's Hospital of Eastern Ontario
Choices for Youth
City of Calgary
City of Red Deer
Clearwater Seafoods Limited Partnership
Coalition for Safe and Effective Pain Management
Coalition solidarité santé
College and Association of Registered Nurses of Alberta
College of Pharmacists of British Columbia
College of Pharmacists of Manitoba
College of Registered Nurses of Prince Edward Island
Communist Party of Canada
Confédération des syndicats nationaux
Conference Board of Canada
Congress of Union Retirees
Connex Health
Conseil du patronat du Québec
Consumer Health Products Canada
Co-operators Life Insurance Company
Core Benefits
Costco Wholesale Canada
Council of Canadians with Disabilities
Council of Senior Citizens of BC
Covenant Health
CPHR Canada
Cystic Fibrosis Canada
D2L Corporation
Dalhousie University
Danish Life Sciences
De dwa da dehs nye>s Aboriginal Health Centre
Dehcho First Nations
Dental Association of Prince Edward Island
Desjardins Financial Security
Diabetes Canada
Dilico Anishnabek Family Care
Doctors Nova Scotia
East Community Health Engagement Committee
Eastern Health
Eli Lilly Canada Inc.
Ellis Health Policy Inc.
Empire Life

Excella Lifestyles
Express Scripts Canada
Families USA
Fancy Pokket Corporation
Federally Regulated Employers – Transportation and Communications
Fédération des chambres de commerce du Québec
Fédération des médecins spécialistes du Québec
Fédération des travailleurs et travailleuses du Québec
Federation of Sovereign Indigenous Nations
Fellows of the Canadian Institute of Actuaries
Finning Canada
First Nations Health Authority
Food Allergy Canada
Fort William Family Health Team Inc.
Friends of Medicare
Giant Tiger Stores Limited
Gibbons Guardian Pharmacy
Gilead Sciences Canada, Inc.
GlaxoSmithKline
Global Public Affairs
Green Shield Canada
Grey Bruce Health Services
Group Medical Services
Gwich'in Tribal Council
H3 Consulting
Halifax Port Authority
Harbourview Family Health Team
Health Advocate
Health Canada
Health Charities Coalition of Canada
Health Consulting Canada
Health Quality Council of Alberta
Health Sciences Association of British Columbia
HealthcareCAN
HealthPRO Procurement Services Inc.
Heart and Stroke Foundation of Canada
Hoffmann-La Roche Limited
Horizon Government Affairs
Horizon Health Network
Horizon Health Patient Experience Advisory Council
HRO Core Inc.
Humania
IAVGO Community Legal Clinic
Independent Voices for Safe and Effective Drugs
Indigenous Primary Health Care Council
Indigenous Services Canada
Inland Technologies
Innovative Medicines Canada
Institut national d'excellence en santé et services sociaux

Institut universitaire de gériatrie de Montréal
Institute for Research on Public Policy
Institute of Health Economics
Inuit Tapiriit Kanatami
Inuvialuit Regional Corporation
Isaac Foundation
Janssen
Johnson & Johnson
Kidney Cancer Canada
Kitchener Downtown Community Health Centre
Kwanlin Dun First Nation
Lakehead Nurse Practitioner-Led Clinic
L'Association francophone des aînés du Nouveau-Brunswick
Le Regroupement provincial des comités des usagers
LGBT Youth Project
Life Sciences Ontario
Little Salmon Carmacks First Nation
Loblaws Companies Limited
Lovell Drugs Limited
Lundbeck Canada Inc.
Magna International Inc.
Manitoba Association of Community Health
Manitoba Blue Cross
Manitoba Chamber of Commerce
Manitoba Health Coalition
Manitoba Metis Federation
Manitoba Nurses Union
Manitoba, Department of Health, Seniors, and Active Living
Manulife Canada
Markham Stouffville Hospital
McKenna, Long & Aldridge
McKesson Canada
McMaster University
Medavie Blue Cross
MEDEC - Canada's Medical Technology Companies
Medical Society of Prince Edward Island
Medical Students Association
Medicine Chest Pharmacy
Memorial University
Mercer Canada
Merck Canada Inc.
Métis National Council
Middlesex-London Health Unit
Mid-Main Community Health Centre
Mi'kmaq Confederacy of PEI
Ministry of Health, Welfare and Sport, the Netherlands
Mississauga Board of Trade
Morneau Shepell
Mount Carmel Clinic

MS Society of Canada
Municipality of Pictou
Munro's Sorrento Prescriptions
Muscular Dystrophy Canada
Myeloma Canada
National Association of Federal Retirees
National Association of Pharmacy Regulatory Authorities
National Council for Behavioral Health
National Council on Aging
National Pensioners Federation
National Union of Public and General Employees
Native Women's Association of Canada
Neighbourhood Pharmacy Association of Canada
New Brunswick Association of Nursing Homes
New Brunswick Association of Social Workers
New Brunswick College of Family Physicians
New Brunswick College of Pharmacists
New Brunswick Dental Society
New Brunswick Federation of Labour
New Brunswick Health Council
New Brunswick Lung Association
New Brunswick Medical Society
New Brunswick Nurses Union
New Brunswick Pharmacists' Association
New Brunswick Senior Citizens Association
New Brunswick Women's Council
New Brunswick, Department of Health
Newfoundland and Labrador 50+ Federation Inc.
Newfoundland and Labrador Board of Pharmacy
Newfoundland and Labrador Dental Association
Newfoundland and Labrador Federation of Labour
Newfoundland and Labrador Medical Association
Newfoundland and Labrador, Department of Health and Community Services
Nishnawbe Aski Nation
North End Community Health Centre
North Shore MicMac District Council
North Slave Métis Alliance
North York General Hospital
Northern Territories Federation of Labour
Northwest Pharmacy
Northwest Territories Health and Social Services Authority
Northwest Territories, Bureau of Statistics
Northwest Territories, Department of Finance
Northwest Territories, Department of Health and Social Services
Northwest Territory Métis Nation
NorWest Community Health Centre
Nova Scotia Cancer Care, Nova Scotia Health Authority
Nova Scotia College of Pharmacy
Nova Scotia Dental Association

Nova Scotia Federation of Labour
Nova Scotia Health Authority
Nova Scotia Health Coalition
Nova Scotia Nurses Association
Nova Scotia, Department of Health and Wellness
Novartis Pharmaceuticals Canada Inc.
Novo Nordisk Canada Inc.
Nunatsiavut Government, Department of Health and Social Development
Nunavut Status of Women Council
Nunavut Tunngavik Incorporated
Nunavut, Department of Finance
Nunavut, Department of Health
Nunavut, Department of Health – Patient Relations
Nurse Practitioner Association of Manitoba
Nurse Practitioner Association of Nova Scotia
Nurse Practitioners’ Association of Ontario
Nurses Association of New Brunswick
OMG Benefits Consulting
Ontario Chamber of Commerce
Ontario College of Pharmacists
Ontario Dental Association
Ontario Federation of Labour
Ontario Health Coalition
Ontario Medical Association
Ontario Minister’s Patient and Family Advisory Council
Ontario Nurses Association
Ontario Pharmacists Association
Ontario, Ministry of Health and Long-Term Care
Ordre des Pharmaciens du Québec
Organigram
Ostomy Society
Pacific Blue Cross
Paediatric Chairs of Canada
pan-Canadian Pharmaceutical Alliance
Patented Medicine Prices Review Board
Patient Advisors Network
PCL Constructors Inc.
PEERS Alliance
PHARMAC - The Pharmaceutical Management Agency of New Zealand
Pharmaceutical Benefits Scheme and Advisory Committee, Australia
Pharmacists Manitoba
Pharmacists’ Association of Newfoundland and Labrador
Pharmacy Association of Nova Scotia
Pharmacy Association of Saskatchewan
Pharmascience
Positive Living Society of Canada
Prince Edward Island Association for Newcomers to Canada
Prince Edward Island College of Pharmacists
Prince Edward Island Federation of Labour

Prince Edward Island Health Coalition
Prince Edward Island Lung Association
Prince Edward Island Nurses Union
Prince Edward Island Pharmacists Association
Prince Edward Island, Advisory Council on the Status of Women
Prince Edward Island, Department of Health and Wellness
Public Service Alliance of Canada
Pulmonary Hypertension Association
Qikiqtani General Hospital
Quebec First Nations
Quebec, Ministry of Health and Social Services
Queen Elizabeth II Health Sciences Centre
Queen's University
REACH Community Health Centre
Regina Community Clinic
Registered Nurses Association of the Northwest Territories and Nunavut
Registered Nurses' Association of Ontario
Registered Nurses' Union Newfoundland & Labrador
Rethink Cancer
Roche Canada
Roy Lounsbury Holdings Limited
Royal Bank of Canada
Royal College of Physicians and Surgeons of Canada
Saint John Human Development Council
Santé Mercer Canada
Saskatchewan Association of Nurse Practitioners
Saskatchewan Cancer Agency
Saskatchewan Chamber of Commerce
Saskatchewan College of Pharmacy Professionals
Saskatchewan Federation of Labour
Saskatchewan Health Authority
Saskatchewan Registered Nurses Association
Saskatchewan Union of Nurses
Saskatchewan, Ministry of Health
Save Your Skin Foundation
SBW Wealth Management & Employee Benefits
Scotiabank
Selkirk First Nation
Senior Liberal Club of Nepean
Seniors Resource Centre of Newfoundland & Labrador
Seniors' Action Yukon
Seniors' Advisory Council of Nova Scotia
Servier Canada Inc.
Shire Pharma Canada ULC
Shoppers Drug Mart
Simon Fraser University
Sinai Health System
Sioux Lookout First Nations Health Authority
Sobeys National Pharmacy Group

Sobi Canada Inc.
Somerset West Community Health Centre
South East Local Health Integration Network
South Riverdale Community Health Centre
Southwestern Public Health
SSQ Groupe financier
St. John's Board of Trade
St. John's Women's Centre
St. Michael's Hospital
Stanton Territorial Hospital
Stewart McKelvey
Stoney Nakoda Tsuut'ina Tribal Council
Sun Life Financial
Suncor Energy Inc.
Surrey Board of Trade
Telus Health
Teslin Tlingit Council
TEVA Canada
The Gathering Place
The Goodman Pediatric Formulations Centre of the CHU Sainte-Justine
The Great-West Life Assurance Company
The Hospital for Sick Children
The Pharmacare Working Group
The Tudor Group
Third Party Administrators' Association of Canada
Thorpe Benefits
Thunder Bay Chamber of Commerce
Thunder Bay Dental Association
Thunder Bay Regional Health Sciences Centre
Tłjchq Government
Toronto Public Health
Treaty 8 First Nations of Alberta
TRG Benefits & Pensions Inc.
Tribal Chiefs Ventures
Tr'ondëk Hwëch'in
Unifor
Union des consommateurs
uniPHARM Wholesale Drugs Limited
Unison Benefits
United Church of Canada
United Food & Commercial Workers
United Nurses of Alberta
Université de Montréal
University of British Columbia
University of Calgary, Department of Economics
University of Calgary, Health Technology Assessment Unit
University of Manitoba, Ongomiizwin Indigenous Institute of Health and Healing
University of Ottawa, Institute of Fiscal Studies and Democracy
University of Regina, Graduate School of Public Policy

University of Regina, Saskatchewan Population Health and Evaluation Research Unit
University of Saskatchewan, College of Medicine
University of Saskatchewan, College of Pharmacy and Nutrition
University of Saskatchewan, Geriatric Medicine
University of Toronto, Dalla Lana School of Public Health
University of Toronto, Institute of Health Policy, Management and Evaluation
University of Toronto, Leslie Dan Faculty of Pharmacy
University of Waterloo
University Women's Club of Montreal
Vitalité Health Network
Waypoint Centre for Mental Health Care
Wellesley Institute
West Community Health Engagement Committee
Willis Towers Watson
Windigo First Nations Council
Winnipeg Chamber of Commerce
Winnipeg Regional Health Authority
Yellowknife Regional Wellness Council
York University
Yukon Anti-Poverty Coalition
Yukon Hospital Corporation
Yukon Pharmacists Association
Yukon Status of Women Council
Yukon, Health and Social Services