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Intelligence MEMOS

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From: Chris Bonnett and Douglas Clark
To: Pharmacare Watchers
Re: THE ART OF THE POSSIBLE: RETHINKING PHARMACARE

On a quiet Friday afternoon last October, the federal government's near decade-long, half-hearted flirtation with pharmacare ended in a whimper. What started with the 2018 Budget's Advisory Council on the Implementation of National Pharmacare, culminated with the release of the Final Report of the National Pharmacare Committee of Experts in 2025.

This latest report will likely be the last of its kind for some time. The Minister of Health quickly distanced herself from its contents, noting that expert panels are "non-binding for the government." Committee members conceded they had not met with the Minister or any of her cabinet colleagues before the report's tabling.

The report itself attributes pharmacare's stalled progress largely to industry lobbying. A more plausible explanation is political and fiscal reality. Over the past year, geopolitical uncertainty and economic pressures have reordered priorities. Budget 2025 contains no new pharmacare funding. The window for sweeping reform has closed, at least for now.

Meanwhile, the federal government's bilateral pharmacare agreements with Prince Edward Island, British Columbia, Manitoba and the Yukon – under which Ottawa provides time-limited funding for specific drugs and devices – remain the primary results of nearly a decade of aspirational change. Quebec and Alberta have publicly declined to participate, and Ottawa doesn't appear to be actively pursuing deals with other provinces.

Polling going back decades shows strong public support for universal drug insurance. Surveys also show that most Canadians are **satisfied** with their drug coverage and have no desire to have it supplanted by a new government program. Therein lies the paradox of pharmacare. Everyone agrees drug insurance is essential, but risk-averse governments, business interests and transformational, idealistic ideas have stymied realistic progress. Patient needs remain unmet. After 80 years and so many attempts, a standard health program in other OECD countries has become virtually Sisyphean in Canada.

Three things keep us locked in a perpetual cycle of policy futility:

1. A moral consensus for change in theory but not in practice: This policy never had a single clear and pragmatic goal, and even the term "national pharmacare" was not clearly and consistently understood.
2. A mismatch between a relatively narrow problem and an oversized solution: The public was not convinced that pharmacare coverage would improve their lives. Since the vast majority of Canadians already have coverage, there was little appetite to invest political or financial capital.
3. Mistrust between senior levels of government and no federal ability, either fiscally or constitutionally, to impose its desired solution: Canada continues to face the massive fiscal problem of post-COVID increases in federal debt and very high deficits.

The reality is that Canada's unique mix of public and private drug coverage has enabled the vast majority of Canadians to access prescription medicines for 50 years. Despite calls for sweeping reforms, we have yet to directly count or describe the Canadians who do not have **any or enough drug insurance**.

We have again been reminded that a public single payer drug insurance model remains politically and fiscally unworkable at the current phase in the evolution of Canadian Medicare. A more pragmatic approach is needed to solve the access problem. Ottawa's Canadian Dental Care Plan (CDCP) offers just such a template. The CDCP provides comprehensive services, targets a defined population with no coverage and lower family incomes, relies on robust private administration, avoids displacing existing insurance, and was fully implemented in just three years.

A Canadian drug plan could use the same design parameters and needs only to add a limit on out-of-pocket drug costs. The Parliamentary Budget Officer could then estimate costs, and consultation on implementation could begin.

No approach is perfect, but a drug plan based on the CDCP would ensure good quality coverage for all Canadians without disrupting existing private or provincial drug plans.

The future for pharmacare must be grounded in the art of the possible. If Ottawa wishes to play a meaningful role, it should focus less on transforming the entire system and more on **closing the gaps** within it.

"The best route forward is uphill," the Expert Committee's report claims, but it is not the single-payer mountain its authors imagined. A CDCP-style drug plan that is income-based, targets the uninsured and doesn't interfere with existing coverage would be both affordable and constitutionally viable. As far as national pharmacare goes, that is a hill we can climb.

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