

Defined by 0.11%: Policies Delimiting Access to Prescription Drugs for First Nations People in British Columbia

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Abstract

The Non-Insured Health Benefits (NIHB) program is a federal program that funds prescription medication, as well as other primary healthcare benefits, for First Nations people registered under the Indian Act and for Inuit. NIHB policies have been developed within the Canadian political realities of ambiguity in interpretation of historical legal obligations, patterns of cost shifting onto provincial governments, and a move towards chronic disease management. This study critiques the ambiguities embedded in NIHB and provincial pharmaceutical benefit policies for First Nations people in British Columbia. British Columbia's Fair PharmaCare and PharmaCare Plan C provincial prescription programs are compared to NIHB. We conducted a review of these policies and completed our understanding by interviewing three pharmacists to better understand decisions surrounding the dispensing process. Four themes surfaced from our analysis: discrepancy between policy and practice in terms of federal versus provincial responsibility; restrictive processes of access to coverage; a system dependent on pharmacists' goodwill when NIHB denies a claim; and NIHB policies at times being at odds with pharmacists' clinical judgment and business compensation. Our findings suggest the existence of an ethnically differentiated social contract that perpetuates rather than diminishes barriers to care for First Nations people.

Keywords

Indigenous, health, British Columbia, prescription, auditor, federal, pharmaceutical, medication, policy

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Introduction

Despite continued conversations about the need for a national pharmacare program (Daw & Morgan, 2012; Gagnon & Hébert, 2010; Rosenfield, 2011), the majority of Canadians requiring prescription medications depend on private insurance and/or out-of-pocket spending to cover costs. Publicly funded coverage is available for some. The federally funded and managed Non-Insured Health Benefits (NIHB) program provides coverage for prescription drugs, in addition to other health services (e.g., eye and dental care), for First Nations and Inuit. The First Nations and Inuit Health Branch of Health Canada (FNIHB), the federal agency that funds and in some reserve communities provides health services to First Nations, takes the firm stance that coverage is provided only to eligible recipients for services that are “not available through any other federal, provincial, territorial, or private health or social program” (FNIHB, 2011, Benefit Criteria, para. 1). This policy is known as *payer of last resort* (Lavoie et al., 2005; Quinonez & Lavoie, 2009; Wardman & Khan, 2001), meaning coverage is provided for NIHB services only if not covered by provincial and third-party insurance plans. In addition, First Nation recipients of provincial employment and income assistance (EIA) are eligible for provincially administered programs that cover the cost of prescriptions. Finally, some provinces (British Columbia, Saskatchewan, Manitoba, Ontario, Nova Scotia, and Newfoundland and Labrador) have developed universal plans to cover “catastrophic” prescription drug costs (Daw & Morgan, 2012).

In British Columbia (BC), Fair PharmaCare provides catastrophic drug coverage based on family income, while PharmaCare Plan C provides prescription medication coverage for EIA recipients (BC Ministry of Health, 2010a). The NIHB and PharmaCare programs use the same privately owned and operated pharmacies for service delivery. The challenge for pharmacists appears when a patient can be covered under multiple programs that may fall in different jurisdictions, with different formularies and eligibility criteria. Little is known about how pharmacists navigate the differences between federal and provincial pharmaceutical coverage programs, when dispensing to First Nation people.

This study documents the influential factors and resulting policy differences that exist between federal and provincial prescription drug coverage programs, and the processes used by pharmacists to compensate for these policy differences in navigating through these coverage programs for BC First Nation clients. This is a timely publication: as of October 2013, the First Nations Health Authority, a BC-wide First Nations health organization, has assumed responsibility for the management of NIHB on behalf of FNIHB. This study provides valuable insights at a key turning point in federal government–First Nations relations.

This paper begins with a discussion of the Auditor General’s 1997 report, which reviewed federal administration of the NIHB program, and the role the report has played in shaping the current structure of pharmaceutical delivery to First Nations people and Inuit in Canada. The discussion is supported by policy documents and published literature, using evidence to support concern with the Auditor General’s interpretation of NIHB clients’ drug utilization patterns. Next, the research methods used to conduct this study are outlined, followed

by the findings section detailing the four themes derived from our analysis. A final section presents key messages and recommendations.

Methods

This article focuses on a detailed review of federal and provincial drug coverage programs. Policy documents were secured through a review of the FNIHB, BC Employment and Assistance, and BC Ministry of Health websites. Three databases (Native Health Database, Medline [OVID], and PubMed Central) were used to retrieve published literature. Key words included First Nations or North American Indian or Indigenous people, Canada, health policy, non-insured health benefits, pharmacy legislation, pharmaceuticals, drug therapy, jurisdiction, and coverage programs. Limits were placed on searches to include only those articles published from 1985 to the present, in the English language. Only seven peer-reviewed articles were identified. Drug coverage policy documents, and associated public and grey literature reports, were analyzed for prescription drug coverage processes and synthesized into flow charts contrasting the decision-making process for federal and provincial pharmaceutical coverage and restrictive drug access for BC residents. The documents reviewed are listed in Table 1.

Table 1
Drug Policy Grey Literature Reviewed in This Study

FNIHB NIHB	<ul style="list-style-type: none"> • Assembly of First Nations. (2005, April 25). <i>First Nations Action Plan for Non-Insured Health Benefits</i>. • Auditor General of Canada. (1997). <i>Report of the Auditor General of Canada to the House of Commons</i>. • FNIHB. (2005, May 12). <i>Executive Summary: Response to the Public Accounts Committee Tenth Report on the Auditor General's Report, October 2000 (Health Canada-First Nations Health: Follow-up)</i>. • FNIHB. (2010a). <i>Non-Insured Health Benefits: Drug Benefit List 2010</i>. • FNIHB. (2010b). <i>Non-Insured Health Benefits Program, Annual Report</i>. • FNIHB. (2011, October 24). <i>Non-Insured Health Benefits for First Nations and Inuit</i>. • Auditor General of Canada. (2000). <i>Report of the Auditor General of Canada to the House of Commons</i>. • Health Canada. (2008). <i>Non-Insured Health Benefits (NIHB) Program's Short-Term Dispensing Policy</i>. • Health Canada. (2010). <i>Report on Client Safety: Health Canada's Non-Insured Health Benefits Program</i>.
BC PharmaCare	<ul style="list-style-type: none"> • BC Ministry of Health. (n.d.). <i>BC PharmaCare Formulary Search</i>. • BC Ministry of Health. (2003, September). <i>Policies and Procedures Manual</i>. • BC Ministry of Health. (2010a). <i>General PharmaCare Coverage Policies</i>. • BC Ministry of Health. (2010b). <i>PharmaCare Trends 2009/2010</i>.

To supplement the policy review, and confirm the decision-making processes for pharmaceutical coverage in BC, we conducted unstructured qualitative interviews with three pharmacists who navigate provincial and federal programs daily. A purposive sampling method was used to select pharmacists who worked in independent pharmacies, for a minimum of 10 years, in a community in northern BC with a population under 100,000 people, many of whom are First Nations (Saks & Allsop, 2007). Pharmacists were approached and asked to participate in a 30-minute interview to discuss administrative differences and complexities within Fair PharmaCare, PharmaCare Plan C, and the NIHB program. All three interviews took place in January 2012, and each was digitally recorded.

Each pharmacist was asked to outline the process involved in navigating multiple pharmaceutical insurance programs to provide clients access to prescription drugs. Pharmacists were asked to outline administrative processes and not their personal beliefs. Further insight into potential solutions or application to other jurisdictions is that of the researchers alone.

Thematic coding (Saks & Allsop, 2007) was used to develop key themes. Key words and themes, identified by repeated explicit and/or implicit meaning within an interview and across multiple interviews, were grouped together. An average of four key words per theme was identified. After selection of key words and the development of each theme, the interview recordings were reviewed again, and direct quotes were selected to provide supportive evidence for each theme.

Results and Discussion

In 1997, the Office of the Auditor General of Canada (OAG hereafter) released a report outlining concerns with the federal management of the NIHB program. This report highlighted prescription drug misuse and “doctor shopping.” “Misuse” was defined as clients filling prescriptions at three different pharmacies and/or obtaining 50+ prescriptions in a three-month period (Auditor General of Canada, 1997, sections 13.98, 13.105). Although the OAG report made specific reference to narcotics as a drug classification of concern, no data were presented on the classes of drug received by those who filled 50 or more prescriptions (Auditor General of Canada, 1997, Table 2). This report set the foundation for current NIHB management policies.

The evidence presented in the OAG report was limited to a statement that 710 NIHB clients each received more than 50 prescriptions in the first quarter of 1996. To get some perspective, we divided this number by the total population of NIHB clients (620,000, the number stated in the OAG report; see Table 2). Although a concern, the percentage of First Nations people and Inuit filling what was presented as an excessive number of prescriptions (at least 50) was only 0.11% of the total eligible NIHB clients. A 2000 follow-up report expressed concerns over the lack of improvement since the 1997 report (Auditor General of Canada, 2000). Our calculations indeed show little change (Table 2).

Table 2

Evidence Provided by the Office of the Auditor General to Inform NIHB Policies (Auditor General of Canada, 1997, Exhibit 13.15; Auditor General of Canada, 2000, Exhibit 15.5)

	For a 90-day period		
	Number of clients going to 3 or more pharmacies	Number of clients getting over 15 different drugs	Number of clients getting at least 50 prescriptions

First quarter of 1996	Total, Canada	15,015	1,599	710
	% of total eligible NIHB clients (620,000)	2.42%	0.26%	0.11%
Third quarter of 1999	Total, Canada	14,077	1,244	998
	% of total eligible NIHB clients (672,000)	2.09%	0.19%	0.15%

In Canada, polypharmacy patterns, defined as the use of multiple medications by a patient, have been studied only for the elderly (Bronskill et al., 2012; Gamble et al., 2014; Kwan & Farrell, 2014; Ramage-Morin, 2009; Reason, Terner, Moses McKeag, Tipper, & Webster, 2012). There has been no study of polypharmacy among First Nations, most likely because NIHB data are difficult to access for research. The existing studies provide limited opportunities for comparisons. For example, Reason and colleagues (2012) defined polypharmacy as the use of five or more prescription medications (time frame not specified) and reported that 27% of Canadian seniors fell into this category. In contrast, Ramage-Morin (2009) reported that in 2005, 12.8% of seniors aged over 65 used five or more medications (time frame not specified). While the comparability of these findings to a First Nations context is limited, they do provide a sense of scale to the data presented above, suggesting that the patterns documented by the OAG may not be exceptional, if one considers the burden of illness borne by First Nations people.

At the time the 1997 OAG report was released, and although not focused on polypharmacy, other literature provided evidence that also challenges the OAG interpretation. For example, Anderson and McEwan (2000) examined the utilization of acetaminophen with codeine, an analgesic commonly prescribed to First Nation individuals who were beneficiaries of NIHB. Unlike the OAG, Anderson and McEwan (2000) also used a non-First Nation comparison group. Using data extracted from government-based pharmacy claims, they showed that crude utilization of acetaminophen with codeine among NIHB clients was moderate and fell within the bounds of a non-First Nations comparison group. Further, Wardman and Khan (2001) documented that crude utilization rates of acetaminophen with codeine were almost four times higher among NIHB clients than the Canadian population at large, yet utilization levels among NIHB clients were somewhat lower than among those covered under BC PharmaCare Plan C for EIA recipients. Wardman and Khan (2001) also noted that drug utilization is influenced by social factors and inferred that analgesic use among PharmaCare Plan C and NIHB recipients is likely influenced by shared social characteristics that contribute to poorer health status and increased burden of disease requiring drug therapy. Additionally, Anderson & McEwan (2000) documented that only 0.7% of NIHB clients residing in BC exceeded the maximum criterion level of 240 mg of codeine per day for 90 days. Finally, we note that the OAG report did not mention that approximately 46% of First Nations people live in an area defined as rural (Browne, McDonald, & Elliott, 2009), which may influence their pattern of access to pharmaceutical services, and dispensing practices.

In response to the OAG's recommendations and despite more balanced evidence reported above, FNIHB tabled plans to (1) increase drug utilization reviews, (2) analyze pharmacists' overrides of system warning messages that occur when potential drug side effects or suspicion of

recreational drug use is present, and (3) upgrade the electronic network to provide system-generated warning codes for pharmacists based on dates, quantities of medication, type of medication, and number of doctors visited (Auditor General Of Canada, 2005, Recommendations and Follow-up Actions, para. 18). The impact of this policy shift is best explored through the experience of pharmacists, as they are the front-line providers tasked with managing the interface between the policy and practice of prescription drug funding mechanisms for First Nations people on a daily basis. Our analysis is organized in four themes, discussed below. Each theme provides an example of how, in practice, First Nations people and Inuit receive substandard care in medication management as a result of FNIHB policy applied to the NIHB program.

Theme One: A Discrepancy Exists between Practice and Policy in Primary Responsibility for Pharmaceutical Coverage

As indicated above, FNIHB's policy explicitly states that the NIHB program is the payer of last resort. Despite this, all pharmacists interviewed described a different state of affairs. To begin, they stated that PharmaCare coverage is available to all BC residents regardless of status (Figure 1). While official documentation (FNIHB, 2010b) states that the majority of registered First Nations people are solely covered under NIHB, each pharmacist described situations where NIHB clients had additional coverage under Fair PharmaCare and/or private insurance, but not under PharmaCare Plan C. If a client has both NIHB and active Fair PharmaCare coverage, PharmaCare provides coverage only if NIHB coverage is denied or if the required prescription drug has been delisted from the NIHB formulary. Thus, it appears that provincial programs, rather than NIHB, are the payers of last resort.

Figure 1 outlines the decision-making process involved in navigating through drug coverage programs that span jurisdictions. A client with a valid prescription is identified for socially insured benefits through a provincially supplied CareCard, a lifetime personal health number for all BC residents who have previously used health services within the province. If the individual does not carry their CareCard, they can be identified through a search within the PharmaNet system (the electronic provincial pharmaceutical adjudication system that connects all pharmacies in BC), using the client's full name and date of birth. The same system also shows eligibility for NIHB coverage.

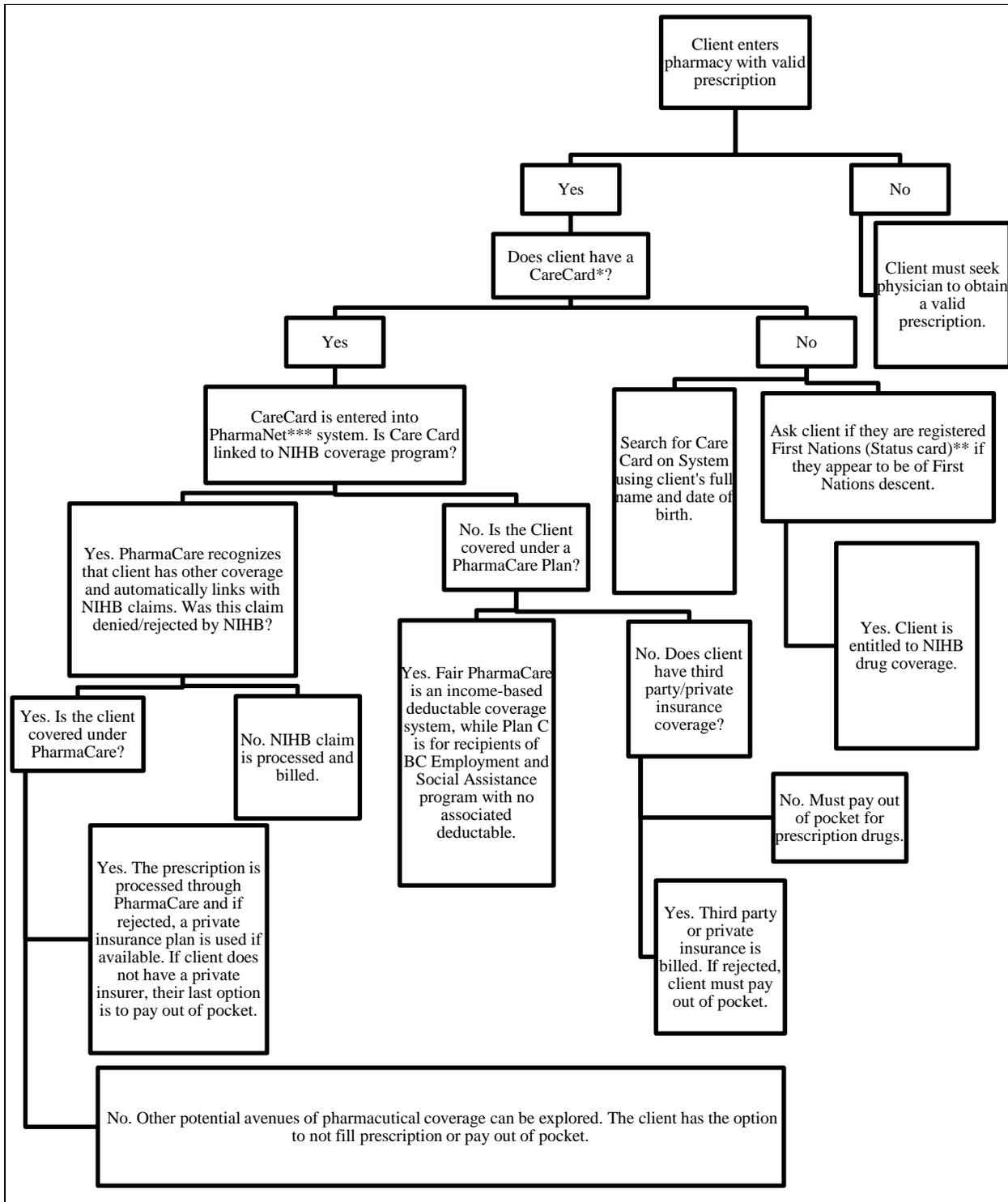


Figure 1. *Flow chart outlining the process and sequence of events followed by pharmacists to navigate through potential multiple coverage systems (NIHB, PharmaCare, and third party or private insurance) for recognized NIHB clients*

Regardless of other potential provincial coverage the client may have, the PharmaNet system automatically adjudicates to NIHB for eligible clients. Individuals who are not registered First Nations, but have coverage for catastrophic drug charges or are recipients of EIA, are automatically adjudicated through the BC PharmaCare system. As explained by one pharmacist: “If someone is [a] NIHB [client], it will be flagged at PharmaCare, so as soon as we try to send a transaction to PharmaCare, it skips them [the client] and does not adjudicate at all” (Interview 3). In spite of official policy statements, “British Columbia definitely wants the federal government to pay before they do” (Interview 1).

These findings are not consistent with current NIHB policy that claims the program to be a payer of last resort for First Nations health services (Assembly of First Nations [AFN], 2005; FNIHB, 2011). This is particularly clear when PharmaCare is used by pharmacists to provide coverage for First Nations clients in cases where NIHB has delisted required drugs or denied a claim (Figure 2). An independent report by the Assembly of First Nations noted that, between 2001 and 2004, 22 items were dropped from the NIHB formulary (AFN, 2005). Although we inquired, we were unable to ascertain whether provincial pharmaceutical coverage formularies were systematically picking up items that were dropped from NIHB formulary. This appears unlikely, however, since differences exist between provincial formularies. The NIHB formulary is defined nationally, with no provincial adaptation.

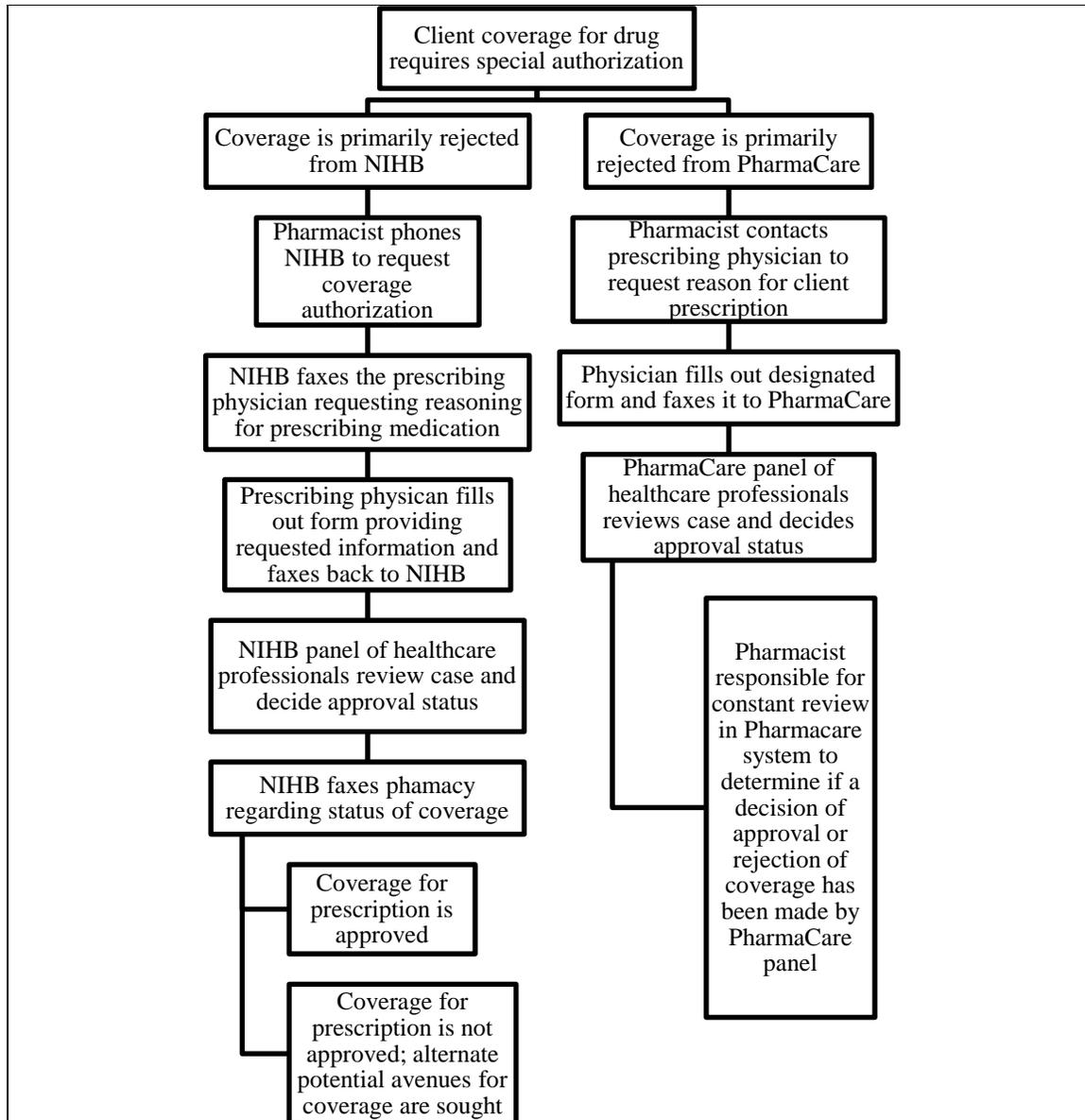


Figure 2.
Contrast between NIHB and PharmaCare programs in restricted drug processes in efforts to provide coverage for prescription drug therapy

Despite uncertainties surrounding NIHB delisted items, the pharmacists interviewed stated that NIHB clients do not necessarily have to be registered for Fair PharmaCare in order to receive provincially provided pharmaceutical coverage. In some cases, pharmacists are able to advocate for temporary coverage until other avenues of funding are secured. In those cases, pharmacists are acting as advocates for patients and are not compensated for time spent securing funding mechanisms for clients. Policy ambiguity over the issue of payer of last resort leads to cost shifting onto provincial programs and opens up potential ethnically defined gaps in pharmaceutical coverage, gaps bridged by the goodwill of pharmacists in navigating unclear funding processes on the clients' behalf.

Theme Two: It is not the Amount of Coverage That is limiting, but More Often Access to Coverage

NIHB and PharmaCare programs categorize prescription drugs as either (a) an open benefit, requiring no additional action by the pharmacist to dispense the prescription, or (b) limited-use benefit (NIHB) or special authority (PharmaCare)—restricted drugs hereafter—requiring additional pharmacist action to provide coverage (BC Ministry of Health, 2010b; FNIHB, 2010a). A prescription drug may be listed as a restricted drug for a variety of reasons, including the availability of lower cost alternatives, association with severe adverse side effects, or potential widespread use for reasons outside of the medical benefit for which the drug is intended (BC Ministry of Health, 2010a; FNIHB, 2010a). All pharmacists interviewed agreed that when a prescription drug is listed as an open benefit, there is no difference between NIHB and PharmaCare programs in the amount of time it takes to dispense it.

Both NIHB and PharmaCare programs have specific processes for limited use and restricted drugs. All pharmacists interviewed highlighted that restricted drug claims occurred more often with NIHB than PharmaCare (Figure 2): “We spend a lot more time getting approvals for medications for the NIHB clientele than we do for PharmaCare Plan C and Fair PharmaCare” (Interview 2). All pharmacists interviewed reported having to use the NIHB limited-use benefit protocol more than three times daily. The NIHB process takes an average of 1–2 days, and up to 7 days for PharmaCare. This is likely due to the division of responsibility between jurisdictions: NIHB demands more action on the part of the pharmacist, while PharmaCare places more responsibility on the physician to provide a rationale for use of restricted drugs (Figure 2). Therefore, it is difficult to determine whether NIHB or PharmaCare restricted drug processes are more inhibiting in terms of access to coverage for First Nations clients; NIHB processing occurs more quickly, yet limited-use benefit drugs requiring additional processing occur more frequently than those listed in PharmaCare’s formulary.

While it is difficult to determine if length or frequency of restrictive drug approval processes directly impacts access for First Nations clients, discrepancies in the approval process for narcotics provide a strong example of limited access due to restrictive processes specific to First Nations people. Point-of-sale warning and rejection messages are used for restricted drugs by both federal and provincial drug coverage programs, to alert pharmacists to unusual use of restricted drugs. Commonly administered prescription narcotics such as oxycodone, codeine, and morphine are categorized as restricted drugs in both programs (BC Ministry of Health, n.d.; FNIHB, 2010a). Within both coverage programs, pharmacists can override messages with electronic response codes, which provide rationale to the governing body for providing the prescription. PharmaCare adjudicates warning and rejection messages based on clients’ last 14 months of dispensed medication in BC with reference to drug interactions, prior adverse reactions, duplicate therapy or ingredients, too high or low dosage, or adherence issues (BC Ministry of Health, 2003). NIHB administers warning and restrictive codes under the same criteria as PharmaCare. An additional NIHB-specific code warns against or restricts prescription narcotic use. The warning and restriction codes for potential misuse of prescription drugs is adjudicated through the NIHB Prescription Monitoring Program: this code activates when a single client attempts to fill a prescription for three or more benzodiazepines, opioids, or a combination of these drugs with methadone (FNIHB, 2010b). To elaborate:

There are more restrictions on narcotics [in the Prescription Monitoring Program] ... while PharmaCare’s system doesn’t have as many restrictions on narcotics. ... You can

fill something a bit early [with PharmaCare] and use your own judgment, where NIHB is very specific. ... With our scope of practice in pharmacy, we are allowed to expend things under our own name with Fair PharmaCare and Plan C, but with NIHB that is not within their protocol so it puts the patient at risk if we are not able to extend medication. (Interview 2)

Additional warnings and restrictions for accessing narcotics through NIHB compared to the BC PharmaCare program degrade pharmacists' ability to provide access to covered medications on behalf of their First Nations clients. It is notable that there is no equivalent warning or rejection message specific to narcotics within BC's PharmaCare program (BC Ministry of Health, 2003). As outlined in our previous discussion, it can be argued that narcotic restrictions unique to NIHB are a result of the interpretation of drug utilization patterns by the Auditor General's 1997 review of the NIHB program.

Theme Three: The System Depends on Pharmacist Goodwill in Provision of Coverage when NIHB Denies a Claim

As claims can be denied or drugs dropped from the NIHB formulary, alternate avenues of coverage have developed over time in an effort to provide access to medication for First Nation clients. Figures 1 and 2 show that five alternative coverage avenues exist for First Nation individuals whose claim is rejected by NIHB. Once NIHB denies a claim, the primary avenue sought by pharmacists is contacting the prescribing physician to inquire whether a substitute medication that is covered by NIHB can be issued to the client. According to one pharmacist, this happens on average two to three times daily (Interview 2). If a substitute medication is appropriate, the physician faxes a new prescription for the client to the issuing pharmacy, and the prescription is filled at no cost to the client.

If a substitute medication is not appropriate, four other avenues, in no preferred order, can be sought by the pharmacist:

- PharmaCare may provide coverage for NIHB clients.
- Local First Nations health organizations provide some situational coverage. Prenatal vitamins were used as an example by one pharmacist as something that had been covered by a local First Nations health organization upon NIHB denial of coverage (Interview 3).
- The client's First Nation community can be contacted to provide coverage on a situational basis.
- If none of the above avenues are successful, the last resort is for the client to either pay out of pocket or not fill the prescription.

No official inter-jurisdictional (federal–provincial) guidelines or policy exists to guide pharmacists navigating through the complexities of multiple coverage avenues. The lack of such guidelines continues to create denials and delays in access in other areas where jurisdictional confusion prevails (Jordan's Principle Working Group, 2015; Lavalley, 2005; Lett, 2008). Additionally, since dispensing fees can only be accessed for drugs dispensed, advocacy that yields no viable option for coverage is not compensated (Interview 3). This creates a system dependent on the goodwill of pharmacists in advocating for coverage.

Theme Four: NIHB Policies are at Times at Odds with Pharmacists' Clinical Judgment and Business Compensation

PharmaCare's policy regarding frequency of dispensing was revised in February 2009, providing a dispensing fee for every 30 days for clients in general (BC Ministry of Health,

2010b). Under this policy, PharmaCare provides one dispensing fee, per day, per drug, per patient at a maximum of three fees daily for clients requiring daily dispensing for medically necessary reasons as defined by their physician (BC Ministry of Health, 2010b).

In contrast, the NIHB's short-term dispensing policy was implemented in 2008, to establish compensation criteria for short-term fills of chronic-use medications when it is medically necessary (Health Canada, 2008). For most medications, the NIHB short-term dispensing policy restricts the number of dispensing fees to 1 per 28 days (Health Canada, 2010). Pharmacists either can choose to fill a 28-day prescription and receive compensation for one dispensing fee, or can bill NIHB every day for daily dispensing but receive only one twenty-eighth of the set dispensing fee (Health Canada, 2008). In 2012, the policy was extended to anticonvulsants, antidepressants, antipsychotics, benzodiazepines, and stimulant medications. When daily dispensing is required, NIHB will compensate one seventh of the usual dispensing fee, up to the NIHB's regional maximum (Health Canada, 2008). NIHB provides one more additional dispensing fee annually for patients who require compliance packaging, where medication is bubble-wrapped with days of the week and time for taking medication (Health Canada, 2008). There is no equivalent in provincial and private drug coverage plans.

Pharmacists stated that the NIHB dispensing policy is more restrictive than that of other plans, resulting in more work for a lesser payment (Interview 2). When clients fill more than one prescription at a time, some prescriptions may be subject to the NIHB short-term dispensing policy and others not: "It would get very confusing for the patient to have 7 days of one thing and 30 days of another, so we would take the [dispensing fee] hit on the cost of that" (Interview 2). Thus, in circumstances where a patient is filling more than one prescription and only select medications are subject to NIHB short-term dispensing policy, pharmacists often have to choose between individually filling prescriptions at staggered times throughout the month to receive complete dispensing compensation, or to dispense all medications at one time for patient convenience and increased compliance. This latter option is the most appropriate for patient care, particularly for clients living in rural and remote environments who must travel long distances to access a pharmacy; this option, however, requires the pharmacist to forfeit some dispensing fees. When contrasting NIHB's and PharmaCare's approaches to dispensing, NIHB focuses on eligibility based on quantity of medication per client, while PharmaCare focuses on eligibility based on the patient's condition and need. Owing to this policy difference, pharmacists are often put in a position where they are forced to choose between their clinical judgment for the best care of their First Nation client, and being fully compensated for their services as a private health professional.

Limitations

We acknowledge a number of limitations to this study. First, we based some of our conclusions on an admittedly small number of interviews. These interviews were meant to document how processes work in everyday practice. Since coverage and exemption rules are static, and we noted consistency across interviews, we believe that theoretical saturation was achieved (Guest, Bunce, & Johnson, 2006).

Also, as healthcare delivery falls within provincial jurisdiction in Canada, the results of this study may not be generalizable to other provinces. Moreover, all pharmacists resided in a single regional centre in BC, and regional discrepancies in health service provision may influence study applicability even within the province. Still, pharmacists were asked to speak to administrative processes and not personal beliefs, therefore increasing the likelihood of validity in the results across BC.

Conclusions

This paper outlined the differences in drug coverage processes between the federal NIHB and BC's provincial Fair PharmaCare and PharmaCare Plan C coverage programs. Our findings show significant differences between the NIHB and the provincial Fair PharmaCare and PharmaCare Plan C, especially with regard to limited-use drugs, for which NIHB regulation continues to be based on evidence from 0.11% of users. We also noted a lack of consistency between NIHB policy and practice, and fiduciary gridlock between the federal and provincial governments' primary responsibility for First Nations pharmaceutical coverage. This situation imposes an unfair burden on the goodwill of pharmacists, which in some cases may compromise access to necessary drugs and patient safety.

It is evident that ambiguity in pharmaceutical coverage processes, increased limitations on pharmaceutical access, and conflicts between pharmacist judgment and NIHB dispensing policies exist for First Nation clients in BC. Our findings suggest that, rather than the principle of equity, access to prescription medication for First Nations is constrained by a series of rules that apply to them alone, suggesting the existence of an ethnically defined social contract within Canada that creates limitations for this already disadvantaged population. In addition, our findings demonstrate the challenges that pharmacists encounter when trying to dispense required medications to First Nations. These challenges have implications for professional practice, patient care, and most importantly, the health of individuals and populations.

As noted in the introduction, this publication is timely. As of October 2013, the BC First Nations Health Authority (FNHA) manages NIHB on behalf of FNIHB. The FNHA is currently engaged in discussions with federal and provincial authorities to address and redress the jurisdictional policy divide where this divide undermines equitable access to services for First Nations. This publication highlights a key area where policy intervention is required.

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