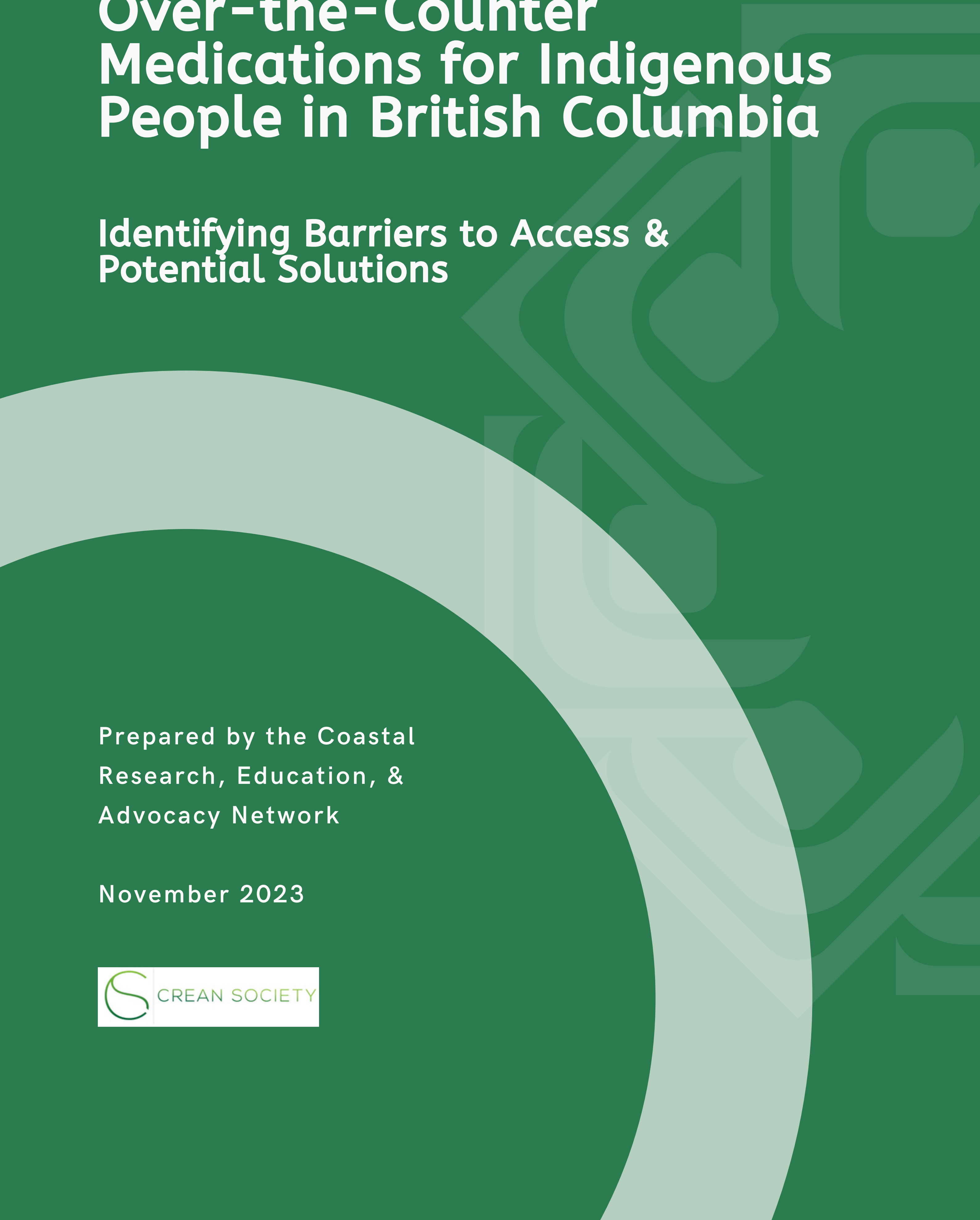
Over-the-Counter Medications for Indigenous People in British Columbia

Identifying Barriers to Access & Potential Solutions



Prepared by the Coastal
Research, Education, &
Advocacy Network

November 2023

CREAN SOCIETY

We respectfully recognize and honour the unceded ləkʷəŋən traditional territory where this work is taking place, and the Songhees, Esquimalt and W̱SÁNEĆ peoples, whose relationships with the land continue to this day. We would like to acknowledge the ways in which settler colonialism produces and perpetuates the conditions of health inequity among Indigenous communities across Canada, as discussed in this report.

The Coastal Research, Education, & Advocacy Network (CREAN) is a non-profit organization dedicated to research, education, advocacy, and other action in the public interest. For more information, please contact: hello@creansociety.org.

CREAN would like to thank the project Advisory Committee and all participants, Daily Dose Society, CREAN staff, and volunteers for their contributions to this study and this report. This report was compiled through the efforts of student researchers and volunteers, including Jake Chaput, Fayelene Pinch, Sai Vemula, Sara Shariarti, Aly Gomes, Iman Jawad, Stephanie Dahling, Erin Must, under the supervision of Anureet Lotay. Any misinterpretation, error, or omission is that of the authors.

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This project has been reviewed and approved by the Community Research Ethics Office:
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Content within this report may be upsetting to some people, especially survivors of trauma. Please practice self-care and take breaks if needed. For additional support, please see resources listed in Appendix A.

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Acronyms

FNHA	First Nations Health Authority
FNHB	First Nations Health Benefit
MSP	Medical Services Plan
NIHB	Non-Insured Health Benefit
OTC	Over-the-counter medications
FNHA Plan W	First Nations Health Benefits Plan Wellness

Executive Summary

From November 2020 to November 2021, the Coastal Research, Education, and Advocacy Network (CREAN) conducted a study examining Indigenous experiences of accessing insurance coverage for over-the-counter (OTC) medications in British Columbia (BC), such as medications for allergy, pain, cold, or flu. One intention of such coverage programs (for example, through the BC First Nations Health Benefits Plan Wellness [FNHA Plan W] or the federal Non-Insured Health Benefit [NIHB] program) is a move toward the reduction of health inequities Indigenous people in Canada face, by covering the cost of OTC medications where they are not covered by other private insurance programs, social programs, and provincial or territorial healthcare plans. Reducing barriers to coverage of OTC medications can help close the gap on health outcomes between Indigenous and non-Indigenous people in Canada.

In 2020, Indigenous community members approached CREAN with concerns about difficulties getting OTC medication costs covered in BC. In response, CREAN established an Advisory Committee of concerned community members, and a mixed-methods study using qualitative and quantitative methodological approaches was undertaken to assess Indigenous community members experiences accessing OTC medications at pharmacies in BC. A survey of 119 Indigenous community members across all health regions in BC was conducted to examine awareness of coverage for OTC medications, the frequency with which individuals accessed benefit/s, barriers to accessing benefits, and potential solutions. Following this, pharmacists (n=11) and Indigenous community members (n=10) were recruited for semi-structured interviews to discuss their experiences in more detail.

The study results show that many Indigenous community members and healthcare providers may not be aware of insurance coverage for OTC medications. The number one reported reason for survey respondents not accessing coverage through insurance programs was that their pharmacist did not know about it (39%, n=44). Within survey responses, 'lack of information' was the most frequent response when participants were asked to identify general barriers to accessing coverage through insurance programs. The majority of both Indigenous interview participants and pharmacist interview participants felt that there was a lack of awareness and information about FNHA Plan W by Indigenous individuals and healthcare providers; that whether individuals obtain coverage can depend on the response of the specific pharmacist/pharmacy; and that additional challenges to obtaining coverage can occur when coordinating with physicians.

Indigenous survey and interview respondents emphasized that experiences of racism and discrimination are common at BC health centres and pharmacies when attempting to access coverage through FNHA Plan W. Forty-seven percent (n=56) of Indigenous survey participants reported that discrimination and prejudice were barriers to accessing insurance coverage for OTC medications. Indigenous participants and pharmacists emphasized that these and other barriers can come together to make coverage for OTC medications more difficult to access and can lead to Indigenous individuals paying out-of-pocket for OTC medications. For example, some study participants who were aware of FNHA Plan W sometimes still paid out-of-pocket for OTC medications in order to avoid racist or negative interactions with healthcare providers. Seventy-four percent (n=88) of Indigenous survey respondents had paid for OTC medications out-of-pocket in the past year.

Participant recommendations to reduce barriers to accessing coverage for OTC medications in BC include increased awareness/information about insurance program coverage details (e.g., more plain language information on provincial coverage shared at pharmacies and health centres, with healthcare professionals, and with Indigenous communities), and increased education and cultural competency/safety by pharmacy staff and healthcare providers. The majority of study participants felt that it would be beneficial to have coverage information all in one place, including clear information about coverages and how to access coverage through FNHA Plan W. Indigenous participants emphasized that information should be in language free of insurance and medical jargon. Pharmacists suggested that program information be shared more clearly through licensing boards, colleges of the health professionals, and in newsletters to pharmacists. Many participants suggested that information could also be shared in informational pamphlets at pharmacies or friendship centres, online through advertising campaigns, or on social media platforms.

1. Introduction

Indigenous people experience individual, community, and societal barriers to healthcare and medication access in Canada (First Nations Health Authority [FNHA], 2015). As the Truth and Reconciliation Commission lays out, there is a need to recognize the rights to health of Indigenous peoples, address the health needs of Métis, Inuit, and off reserve Indigenous peoples and close the gaps on health outcomes between Indigenous and non-Indigenous people (Truth and Reconciliation Commission of Canada [TRC], 2015). At the societal level–which pertains to the historical and current colonial practices in Canada–it is important to consider the numerous sources of trauma that Indigenous people have faced, such as displacement (e.g., residential schools, 60's scoop), segregation, institutional research, and clinical practices carried out without consent (TRC, 2015). At the community level, the lack of investment from health care providers and pharmacists is a concern for health (Turpel-Lafond, 2020). Underlying factors for this include the complexity of service provision and institutional funding structures (divided between federal, provincial, and community programs). In addition, racial discrimination–often compounded with communication barriers–can further complicate how Indigenous people interact with healthcare services (Allan & Smylie, 2015; Baker & Giles, 2012; Kelly & Brown, 2002). Although steps are being taken to address health inequities in many Indigenous communities, colonial legacies continue to hinder wellness. At the individual level, Indigenous voices have rarely been given consideration in designing health care and pharmacotherapy (the use of one or more pharmaceutical medications to treat health conditions) provisions (Turpel-Lafond, 2020).

This study looks at one barrier to accessible healthcare for Indigenous people in British Columbia, Canada: access to, provision, and use of over-the-counter medications through the FNHA Plan W program. OTC medications, also referred to as non-prescription drugs, are used to treat many conditions, such as chronic pain, allergies, cold, flu, and more. While OTC medications are not covered under most extended health insurance plans, the Non-Insured Health Benefits (NIHB) for First Nations and Inuit people in Canada and FNHA Plan W in British Columbia (BC) are intended to cover the cost of many OTC medications and reduce barriers to healthcare access for Indigenous populations. While this study focuses on experiences of access and barriers in relation to FNHA Plan W, evidence suggests that these experiences are also relevant to the NIHB and other medical insurance programs in Canada (National Collaborating Centre for Indigenous Health [NCCIH], 2019).

This project was undertaken after an Advisory Committee composed of Indigenous community members and pharmacists raised concerns about the accessibility of OTC medications under the FNHA Plan W program in BC. This project aims to explore those concerns by investigating the experiences of Indigenous community members and pharmacists in BC.

2. Methodology

A. Study Design and Approach

This study used qualitative and quantitative methodological approaches in social sciences to understand experiences of access to OTC medications in relation to FNHA Plan W in BC. An anti-oppression framework was utilized, and ethical practices and processes embedded in community-based research. The research questions and materials were developed in collaboration with Indigenous community members in Victoria, BC, and an Advisory Committee of Indigenous individuals was formed to guide the research process. Ethical consent was obtained for the study through the Community Research Ethics Office in 2020, and principles of Free, Prior, and Informed Consent (FPIC) were used throughout the research. All participants were given a participant ID number to protect confidential information.

Between November 2020 and November 2021, an online survey and semi-structured interviews were conducted to assess:

i) Awareness, understanding of, and attitudes towards, OTC medication benefits and FNHA Plan W, by Indigenous individuals and pharmacists; and,
ii) Barriers to Indigenous individuals accessing OTC medication benefits through FNHA Plan W.

A mixed-methods design was chosen to gather and amplify Indigenous voices and concerns related to the topic. Mixed-methods studies can produce robust results, given that information is gathered from multiple sources and comparing and analyzed together (Smajic et al., 2022). Convenience sampling was used for the online survey, while purposive sampling was used for interview participants. These methods were used to try to appropriately reach the maximum number of participants possible during the COVID-19 pandemic. Contact information was collected for a focus group, but due to the pandemic, this was not able to take place.

B. Data Collection and Analysis

Online Survey

To explore Indigenous individuals' experiences of medication access in BC, an online survey was developed in collaboration with the projects' Advisory Committee. Participants were recruited by Facebook and email communication. Community organizations, First Nations leadership, friendship centres, and community centres in BC were contacted by email and asked to distribute the survey to their members. The survey, consisting of 25 questions, was available on SurveyMonkey from October 2020 to January 2021. The completion rate of the survey was 98%, with 119 Indigenous participants completing it.

At the end of the survey, participants were asked to enter their email address if they wished to be entered into a draw for $50 Amazon gift cards, or if they were interested in being interviewed to expand on their answers. Survey results were analyzed descriptively. SurveyMonkey and Microsoft Excel were used to analyze and visualize the data, create tables, quantify, describe, examine and compare trends and patterns in the data set. Canva was used to create infographics.

Semi-structured Interviews

Indigenous Participants

Indigenous survey participants who expressed interest in sharing more details about their experiences with researchers were contacted by email for an interview. In total, ten Indigenous community members were interviewed on Zoom, by telephone, or in person. Interview questions discussed participants use of OTC prescription medication insurance programs, experiences, and barriers faced.

Pharmacists

In order to examine attitudes and experiences of FNHA Plan W from a health care providers perspective in BC, semi-structured interviews were conducted with pharmacists. Pharmacists were recruited by telephone calls to pharmacies from November 2020 to March 2021. Interviews were scheduled and conducted over the phone with 10 pharmacists and one pharmacist technician. Interviews discussed pharmacists’ experiences providing prescriptions for Indigenous clients, including the process, barriers, and challenges.

All interviews were analyzed using inductive thematic analysis (Braun & Clarke, 2012). Qualitative data was completed by identifying, classifying, categorizing and coding it into workable themes. To ensure consistency and accurate representations of data, the initial coding was reviewed collaboratively with the research team to ensure agreement on the process. Interview transcripts were coded by two research assistants, after which the research team reviewed to determine the global themes.

3. Literature Review

The following subsections provide a brief overview of the landscape of Indigenous healthcare in Canada, including a short description of the programs currently providing coverage for Indigenous populations.

A. Historical Background & Inequity/Inequality in Canada's Healthcare System

Prior to contact with colonizers, Indigenous people's lifestyle included gathering, hunting, and farming food in diverse ways depending on the region, climate, and socio-ecological context; this lifestyle created well-being among Indigenous communities, and spiritual healers played an important role in contributing to holistic health (First Nations Health Council [FNHC], 2011). There were also specialist healers who understood the medicinal qualities of many plants and used these to help cure and prevent ailments within communities (FNHC, 2011). Overall, the pre-contact health of Indigenous people was robust. This abruptly changed following contact with colonizers; epidemics of smallpox, whooping cough, influenza, and measles ravaged populations. It is estimated that 90% of the Indigenous population in what is now BC was lost; in many of these cases, if Indigenous people had received basic care, they would have survived (FNHC, 2011).

The cultural genocide of Indigenous people in Canada included repressing traditional healing practices; in addition, low-quality and oftentimes non-existent healthcare was and has been delivered to Indigenous people (FNHC, 2011). The 1876 Indian Act included a few non-specific lines about healthcare for Indigenous people (FNHC, 2011). At the turn of the

20th century, segregated “Indian Hospitals”, where care was significantly worse at standard hospitals of the time, became commonplace. These hospitals also frequently resulted in the separation of families over large distances, which still occurs today with medical relocations due to care not being available in remote locations (NCCIH, 2019). This remained the status quo for many years, culminating in a white paper produced by the federal government in 1969, which advanced policy targeted at formally assimilating Indigenous people (FNHC, 2011). This led to large-scale activism by Indigenous people and eventually led to the protection of Aboriginal and Treaty Rights in the Canadian Constitution in 1982 (FNHC, 2011). However, because Indigenous people are under federal jurisdiction, this has led to complications surrounding who is responsible for funding Indigenous healthcare (FNHC, 2011).

Healthcare policies and institutional medicine in Canada affecting Indigenous people have so far often been based on colonial beliefs and practices (Medical Council of Canada, 2020). European settlement in Canada was accompanied by numerous colonial policies which hurt Indigenous communities in various–often irreversible–ways. Segregation of Indigenous peoples within Canada’s healthcare system was entrenched with racist beliefs that Indigenous peoples should be treated separately, and that they were to be treated as objects and not as patients, and these beliefs were supported and intertwined with other policies of assimilation in Canada (Turpel-Lafond, 2020, pp. 156-157; TRC, 2015). In the late-19th and early-20th century, Indigenous patients were treated in “Indian hospitals” which had fewer resources and health care providers available compared to other hospitals in Canada. Indigenous patients experienced subpar medical services (Lux, 2010). Racial segregation of medical care in Canada led to certain illnesses, such as tuberculosis, to be labelled as “Indian” which, in turn, caused the characterization of Indigenous people as “racially careless” concerning their own health (Lux, 2010). This public view of Indigenous communities compounds the consequences of suboptimal healthcare services which Indigenous people received, contributing to worse health outcomes among Indigenous people in Canada (Turpel-Lafond, 2020).

Even during the mid-20th century, Indigenous community members in Canada were still treated in different parts of hospitals, such as basements, compared to others; this segregated healthcare system, along with residential schools and Indian reserves, were intended to keep certain diseases, such as tuberculosis, confined to Indigenous communities (Lux, 2010). However, these systems of oppression themselves contributed to the further spread of many chronic and infectious diseases among Indigenous communities. For instance, in 1927, a group of researchers in BC found that the raw milk used in residential schools contributed to the spread of tuberculosis among Indigenous children, but the Department of Indian Affairs did not release these findings (Lux, 2010).

The legacy of colonialism and racial segregation is still present in Canada's healthcare system. A report published by Turpel-Lafond (2020) found that Indigenous respondents were two to two and a half times more likely than non-Indigenous respondents to report "always" having difficult experiences in healthcare due to stereotyping and discrimination, with only 16% of Indigenous respondents saying that they did not experience discrimination related to stereotyping (pp. 23-24). Due to the racism and discrimination faced by Indigenous people in Canada's healthcare system, there is often a lack of trust in health care providers or an overall avoidance of seeking healthcare (FNHA and Office of the Provincial Health Officer [OPHO], 2021, pp. 48-53). This avoidance may increase disease severity of illness, lead to higher rates of undiagnosed illnesses, or lead to a higher rate of hospitalizations that could have been avoidable (FNHA and OPHO, 2021).

A 2003 study found that 61% of First Nations respondents felt that their culture and beliefs were disrespected in Canada's medical system, and this feeling of disrespect was accompanied by distrust in the healthcare system (Li, 2017). Many Indigenous Elders and healers view the dismissive attitude towards their traditional medicines and ways of knowing–which is prevalent in the Western medical system–as another way of restricting their culture and erasing their history (Li, 2017). This lack of respect and understanding for Indigenous culture in healthcare settings also exacerbates the power imbalance and distrust that exists in interactions between Indigenous community members and care providers (Turpel-Lafond, 2020).

Indigenous people living in rural areas continue to experience several additional barriers to healthcare access that can create or exacerbate health inequities. Geographical location can be a barrier to healthcare access among Indigenous communities; many reserves are rural, and over 80% of First Nations and Inuit communities are considered remote, with one quarter of Métis living in a rural or remote area–living physically further from healthcare clinics and hospitals than other Canadians (Loppie and Wien, 2022, p. 28). Availability of healthcare services in rural areas is another issue; if hospitals and healthcare facilities are accessible for First Nations people living on reserve, many important services, such as screening or preventative care, might not be provided there due to unavailability of supplies and resources (Horril et al. 2018). Many Indigenous patients living on reserve rely on specialists who travel there only once a month (Rana et al., 2004). These physical barriers, along with the cultural barriers, limit Indigenous people's access to healthcare (Horril et al., 2018).

Research suggests language barriers continue to prevent Indigenous individuals from accessing healthcare in many different spheres. According to Bowen for Health Canada (2001), a significant proportion of Indigenous people in Western cities may lack language capability to communicate in an official language during health care situations. They may also feel stress or face access and communications problems when their primary language is not English or French (Turpel-Lafond, 2020; NCCIH, 2019). As another example, a study conducted in Nunavut revealed that while the Inuit Language Protection Act required all essential services to be provided in the four official languages of the territory (English, French, Inuktitut, and Inuinnaqtun), the majority of verbal communication in healthcare settings happened in English due to the under-representation of Inuit among healthcare workers (Romain 2017).

B. Health Disparities in Indigenous Populations

Rooted in Canada's colonial history, ongoing inequities, inequalities, and discrimination in the healthcare system contribute to health disparities between Indigenous and non-Indigenous populations in Canada (Gunn, 2016). The World Health Organization acknowledges the impacts of colonization on Indigenous health (such as intergenerational trauma, poverty, lack of housing, clean water) (True North Aid, n.d.). While the statistics vary between areas and populations, Indigenous people in Canada continue to have lower life expectancy rates than non-Indigenous populations in Canada (Tjepkema et al., 2019). According to The First Nations Regional Health Survey, the most commonly reported conditions for are as follows (First Nations Information Governance Centre [FNIGC], 2018):

- Allergies
- Arthritis
- High Blood Pressure
- Diabetes
- Chronic Pain
- Obesity/being overweight

Certain health conditions are statistically more prevalent in Indigenous populations in Canada (Public Health Agency of Canada [PHAC], 2018). For example, diabetes is up to three times more prevalent in Indigenous populations, especially for on reserve residents (PHAC, 2018, p. 195; Indigenous Services Canada, 2021). The most recent measures of diabetes (FNIGC, 2018; PHAC, 2011) show a prevalence of 15.9% in First Nations individuals who live on reserve compared to a prevalence of 5.6% in non-Indigenous individuals. These disparities could be attributed to cultural and geographical differences between Indigenous groups as well. For example, First Nations individuals living off reserve report a diabetes prevalence of 10.3% while Métis individuals report a prevalence of 7.3% (PHAC, 2011). Differences in chronic health conditions also exist when comparing Indigenous populations in northern Canada to southern Canada, overall indicating that treatment options, or systems solutions must consider the uniqueness of Indigenous identity and their community (Earle, 2013). Mood and anxiety disorders, suicide rates, and obesity and overweightness issues disproportionately affect youth (PHAC et al., 2022).

Incidence and survival rates of cancer also differ in Indigenous populations compared to non-Indigenous populations in Canada. A longitudinal study examining five-year survival rates found that First Nations individuals living both on and off reserve had poorer survival rates for 14 of the 15 most common cancers, compared to the non-Indigenous cohort (Withrow et al., 2017). In BC, higher incidence rates for colorectal and ovarian cancers in First Nations individuals was also found, as well as an upward trend in incidence rate for lung cancer (McGahan et al., 2017). The researchers highlight the First Nations versus non-First Nations disparities in incidence and survival rates as consequences of poor access and utilization of the province's healthcare system (McGahan et al., 2017).

A combination of health harming determinants and poor access to treatment options in Canada lead to alarming observations of poor health in Indigenous communities (Loppie & Wien, 2022). The COVID-19 pandemic exacerbated existing social and economic inequalities in Canada (Canada, 2021). Lack of funding restricted the development of community-led public health infrastructure and response to the pandemic (Mashford-Pringle et al., 2021). High prevalence of pre-existing health conditions such as high blood pressure, diabetes, chronic bronchitis and heart disease in Indigenous populations increase the risk of COVID-19 complications (Statistics Canada, 2020). Statistics Canada also reported worsening mental health (2020), sometimes leading to an increase in substance abuse, anxiety, and PTSD during the lockdown periods (Flores et al., 2022). Physical distancing restrictions also cut many people off from their cultural practices and social connections; if residents left their reserves, they were not allowed to return, leaving them without their support systems (Mashford-Pringle et al., 2021).

While some data shows that Indigenous food security was challenged during COVID-19 due to limitations in sharing traditional foods, and the need to abide by physical distancing measures, other data shows that communities increased land-based approaches for food harvesting and preparation (Mashford-Pringle et al., 2021). Some participants and communities reflected that the key to their management of COVID-19 was a community health team who were able to incorporate cultural and traditional knowledge with biomedical approaches (Mashford-Pringle et al., 2021). New studies are reporting that some Indigenous communities in Canada feel that they are successfully persevering through the COVID-19 pandemic by maintaining culturally relevant connections with family-centred and land-based approaches to physical health and wellness that have been practiced for generations (Benji et al., 2021).

C. Overview of Indigenous Healthcare Provision and Benefits Programs in Canada

The Canadian healthcare system divides responsibility for providing services between federal and provincial or territorial jurisdictions (Government of Canada, 2019a). The federal government is primarily responsible for setting the standards for care under the Canada Health Act (Government of Canada, 2019a). The provincial and territorial governments are then responsible for the delivery of healthcare under the Canada Health Act (Government of Canada, 2019a). They use provincial or territorial funding, along with federal and tax funding to provide medically necessary services (Government of Canada, 2019a). The federal government is also responsible for administering supplementary services to populations, such as Indigenous people, armed forces members, veterans, and certain refugee groups (Government of Canada, 2019a).

As it currently stands, Indigenous people have access to the provincial healthcare system and benefits from the federal government. The federal government program that provides supplementary services for Indigenous people is called the NIHB (Government of Canada, 2022a). This program covers vision, dental, mental health counselling, medical supplies and equipment, prescriptions and OTC medications, and medical transportation (Government of Canada, 2022a). According to the Government of Canada NIHB website, to be eligible for the program, one must be a Canadian resident and meet one of the following criteria:

1. A First Nations person registered under the Indian Act.
2. An Inuk recognized by the Inuit land claim organization.
3. A child under 18 months old whose parent is a registered First Nations person or a recognized Inuk (Government of Canada, 2022a).

In addition, to access the benefit program, one must be in possession of a status Indian card and utilize their identification number for approval (Government of Canada, 2022a). The purpose of the program is to cover medications or services that are not covered by other private insurance programs, social programs, and provincial or territorial healthcare plans (Government of Canada, 2022a). This program is seen as vital in closing the health gap that remains prevalent in Canada (NCCIH, 2019). The NIHB website indicates that a prescription is required to access any of the drugs on the list (Government of Canada, 2022b). By definition, a medication is not an OTC drug if a prescription is required; it then becomes a prescription drug.

D. Indigenous Healthcare Provision and Benefits Programs in British Columbia

The First Nations Health Authority (FNHA) took over the administration of the NIHB from the federal government for Indigenous BC residents in 2013, assuming its responsibilities and duties with the aim of allowing Indigenous people to have more control over the implementation of better healthcare for their communities (FNHA, 2013). Those who remain covered under NIHB in BC are either Inuit, or individuals associated with BC nations that reside in other provinces or territories in Canada (Indigenous Services Canada, 2023). The FNHA implemented the First Nations Health Benefit (FNHB), where health benefits that were previously under NIHB are now covered by BC-based providers; this is intended to cover health care costs not covered by third-party health insurance (FNHA, 2019). The

FNHA is funded by both the federal and provincial governments to provide the First Nations Health Benefits (FNHA, 2022a). The FNHA has a partnership that began in 2019 with Pacific Blue Cross to administer dental, vision care, medical supplies and equipment, and some pharmacy items and services (FNHA, 2019). In 2017, the FNHA transitioned pharmacy coverage from the federal program to partner with BC Pharmacare to administer FNHA Plan W. Lastly, FNHA has partnerships with First Nations bands and organizations in order to provide medical transportation and mental health care for individuals (FNHA, 2019).

The FNHA provides coverage for ambulance invoices, dental, vision care, medical supplies and equipment, pharmacy, medical transportation, and mental health (FNHA 2019). Their complete guide to their Health Benefits program can be found here.

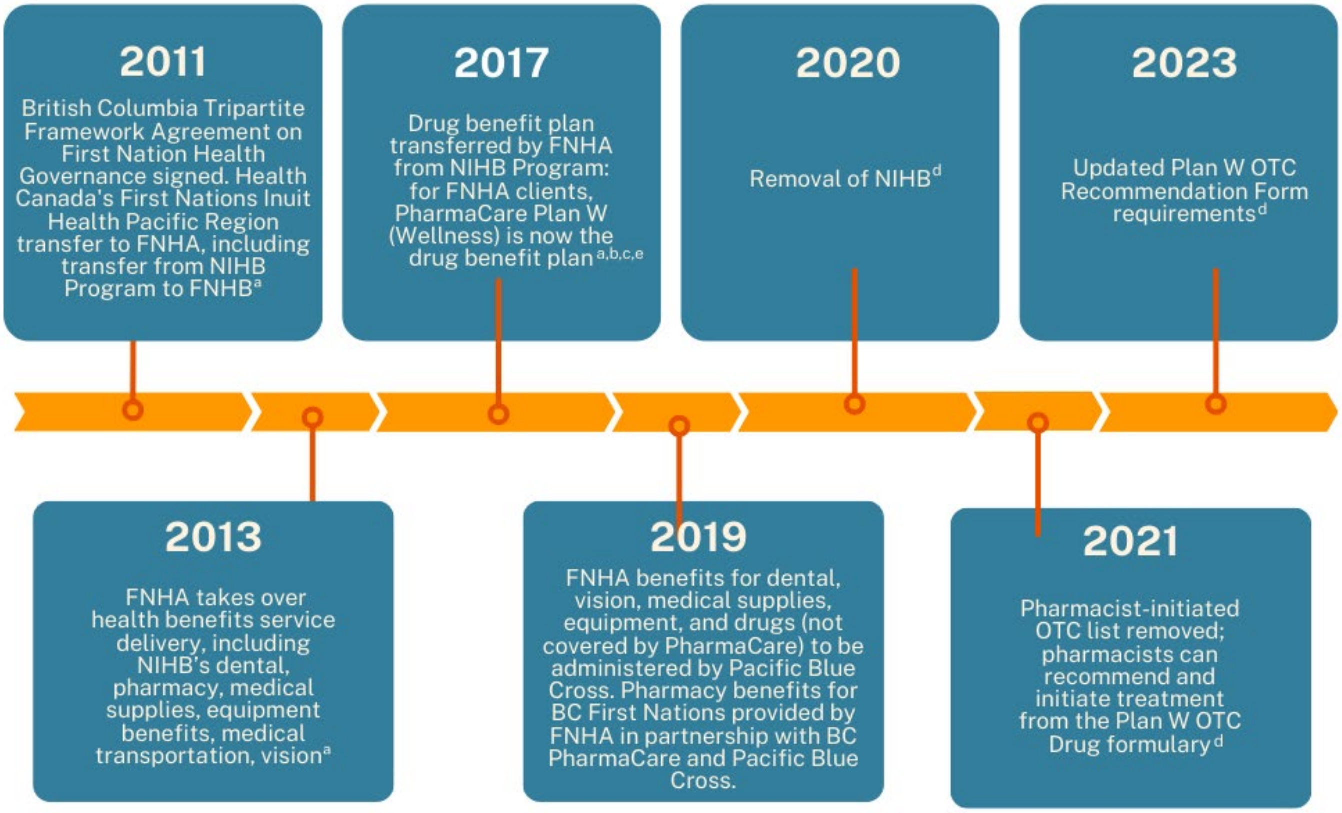
According to the FNHA (2019) guide, to be eligible for FNHA Benefits individuals must be:

1. Are a registered Indian under the Indian Act, or the infant of an eligible parent;
2. Be a resident of British Columbia.

If individuals are to permanently move out of BC and to another part of Canada, they need to contact FNHA Health Benefits to cancel and then enrol in the federal NIHB program (FNHA, 2019). As for FNHA Plan W, eligibility must be confirmed by FNHA. There is no need to apply for Plan W, but you must be enrolled with FNHA. According to BC PharmaCare (2023), to be eligible for FNHA Plan W coverage, individuals must:

1. Have active Medical Services Plan (MSP) coverage. To enrol in MSP, contact FNHA.

2. Are a registered Indian under the Indian Act, or are a child under 2 years who has at least one parent who is a registered Indian under the Indian Act.



2011

British Columbia Tripartite Framework Agreement on First Nation Health Governance signed. Health Canada's First Nations Inuit Health Pacific Region transfer to FNHA, including transfer from NIHB Program to FNHB[a]

2013

FNHA takes over health benefits service delivery, including NIHB's dental, pharmacy, medical supplies, equipment benefits, medical transportation, vision[a]

2017

Drug benefit plan transferred by FNHA from NIHB Program: for FNHA clients, PharmaCare Plan W (Wellness) is now the drug benefit plan[a,b,c,e]

2019

FNHA benefits for dental, vision, medical supplies, equipment, and drugs (not covered by PharmaCare) to be administered by Pacific Blue Cross. Pharmacy benefits for BC First Nations provided by FNHA in partnership with BC PharmaCare and Pacific Blue Cross.

2020

Removal of NIHB[d]

2021

Pharmacist-initiated OTC list removed; pharmacists can recommend and initiate treatment from the Plan W OTC Drug formulary[d]

2023

Updated Plan W OTC Recommendation Form requirements[d]

Figure 1: Summary of key dates in the development of the First Nations Health Authority Plan W (CREAN's interpretation of events as described by sources from FNHA and outside FNHA)[1]

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[1] Source for Figure 1:
a: https://www.fnha.ca/benefits/overview
b: https://www.fnha.ca/BenefitsSite/PharmacareTransitionSite#:~:text=The%20FNHA%20joined%20BC%20PharmaCare,forms%20or%20registration%20is%20required.
c: https://www.fnha.ca/Documents/Evaluation-of-FNHAs-Health-Benefits-Pharmacy-Program-for-BC-First-Nations.pdf
d: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacare-publications/pharmacare-policy-manual-2012/coverage-plans/first-nations-health-benefits-planw
e: https://www.bcpharmacists.org/readlinks/guest-post-increasing-wellness-through-pharmacists-providing-otcs
f: https://www.fnha.ca/benefits/health-benefits-news/health-benefits-policy-changes

Some individuals do not qualify for coverage for FNHA Plan W because they have coverage through other agreements with Canada (see here).

In September 2021, the FNHB program removed the pharmacist-initiated list used, thus allowing pharmacists themselves to recommend treatment (see Figure 3). Before this, obtaining OTC medications required a prescription from a health care provider, as shown in Figure 2 (e.g., a general practitioner/doctor). After 2021, BC PharmaCare and the FNHA amended the policy such that all OTC medications covered under FNHA Plan W could either be dispensed with a prescription from a health care provider, or pharmacy initiated with the proper procedures. The full list of OTC medications was also made available for both pharmacists and public access (Government of British Columbia, 2022). The recent change to allow pharmacist-initiated OTC medication administration makes this process more streamlined and potentially allows for Indigenous people to access their benefit more readily (Figures 2 and 3).

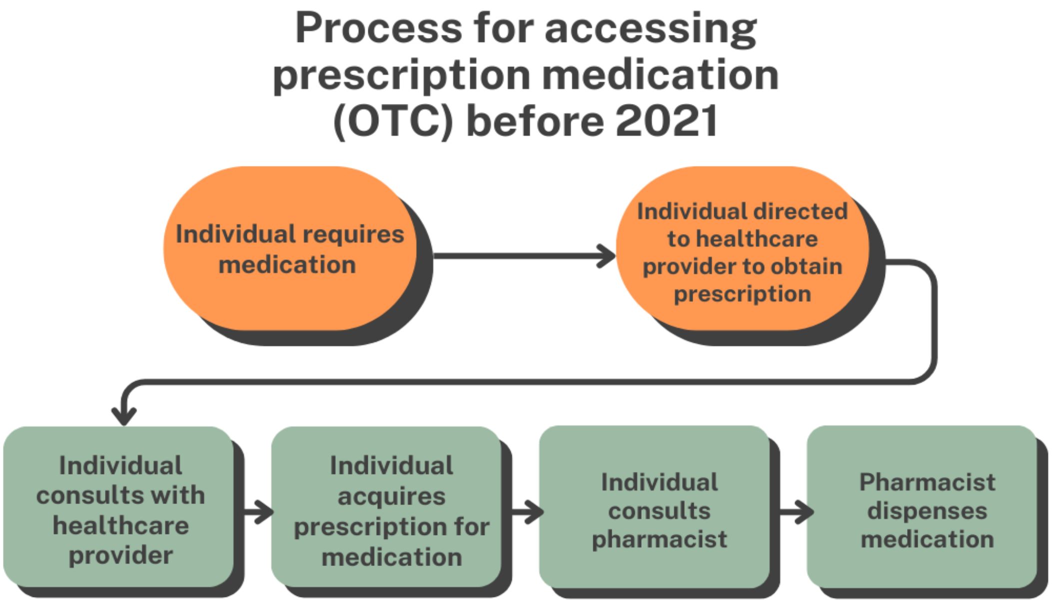

Figure 2: OTC medication benefit access before 2021 (CREAN's interpretation as described by FNHA and other sources)

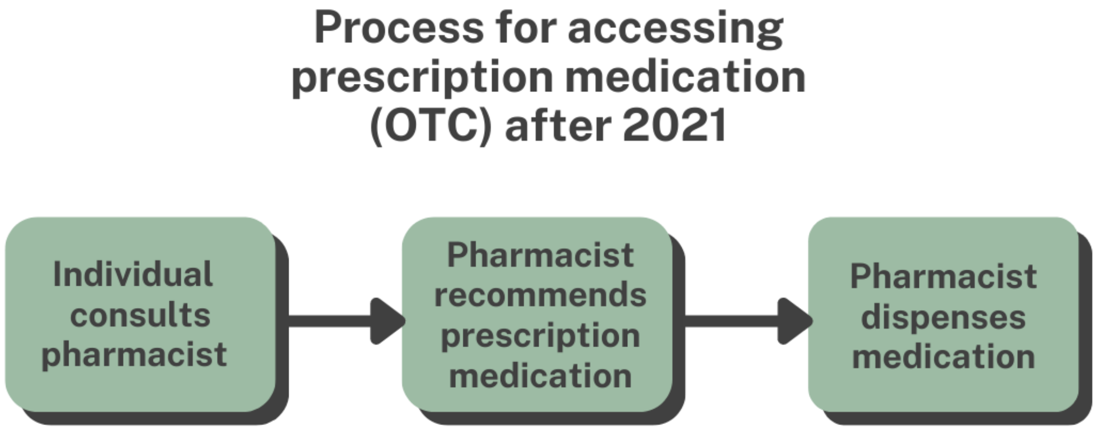

Figure 3: The process for a client to access the OTC medication benefits as of September 2021, illustrating pharmacy-initiated OTC claims (CREAN's interpretation as described by FNHA and other sources)

E. Over-the-Counter Prescription Medication

OTC medications can play an important role in reducing adverse health outcomes. They can be used as acute treatment for maladies, or as preventive medicine, by improving access to essential nutrients such as vitamins and minerals. OTC medications and other prescriptions can be used to treat short-term illnesses, but can also help those with chronic conditions live healthier lives (FNHA, 2019). Given the health inequities faced by Indigenous people in Canada, programs such as FNHA Plan W that increase access to OTC medications can play an important role in improving Indigenous health outcomes.

In recent years, pharmacists, health care providers, and Indigenous community members have voiced concerns about insurance programs designed to reduce health inequities for Indigenous people (Assembly of First Nations, 2017; Morrison, 2015). These problems have led to a lack of awareness among Indigenous people about the benefits they may be eligible for (Assembly of First Nations, 2017). In 2015-2016, 61% of eligible Indigenous clients utilized the NIHB pharmacy benefits nationally (a three percent reduction compared to 2010-2011 (Assembly of First Nations, 2017). Although restrictions have lessened as of 2020 and 2021 for pharmacy benefits programs both nationally and provincially as a response to the increased burden of COVID-19 (First Nations Health Authority [FNHA], 2022b; Indigenous Services Canada, 2020a), some barriers remain. For example, reimbursements are only provided at registered pharmacies.

Overall, approximately 22% of prescription drug costs in Canada are paid out-of-pocket (Heart & Stroke, 2019). Canada is the only universal public health insurance system that does not include the universal coverage of prescription drugs used outside the hospital setting (Morgan & Boothe, 2016). Canada has one of the highest expenditures per capita on pharmaceuticals; expenditures have increased by 27%, although the percentage of Gross Domestic Product (GDP) spent on pharmaceuticals remains at around 1.8% (Organisation for Economic Co-operation and Development [OECD], 2019). Compared to other OECD countries, Canada has the fourth highest drug spending per capita (behind Germany, Switzerland and USA). It has consistently remained the third highest spender for a majority of the last ten years (Government of Canada, 2019b; Organisation for Economic Co-operation and Development, 2019). These expenditures are 42% higher than the median of comparable health systems (Morgan & Boothe, 2016). Out-of-pocket spending on prescription medications in Canada is greatest among those in the second lowest income quintile (Heart & Stroke, 2019). Income inequality exacerbates the effects of out-of-pocket medication costs on Indigenous people. In 2015, the median total income among Indigenous people on reserve was $18,445 while the same figure among non-Indigenous Canadians was $30,755 (Statistics Canada, 2016).

Cultural competence and cultural safety are important for communicating and connecting to Indigenous patients, especially at pharmacies, which often serve as the first point of contact for medical care for rural or remote communities (First Nations Health Authority, 2022c). Effective patient-pharmacist communication is especially important for OTC medications, as the responsibility of facilitating the appropriate usage of these medications generally falls on pharmacists (Seubert et al., 2017). Studies have shown that as many as

28% of hospital emergency visits in Canada are drug-related, of which 70% are preventable (Patel & Zed, 2002). Effective patient-provider communication can substantially lower the risk of these adverse drug events, which mostly result from improper usage or dosing of pharmaceuticals (Romain, 2013). Many pharmacists do not understand the trauma experienced by Indigenous communities and its present-day ramifications (Pharmacy Connection, 2020, p. 19):

> *How can you treat a First Nations patient equitably if you don't know what the residential schools were, if you don't know what the Sixties Scoop was, if you don't know that most children in the province who are apprehended are First Nations because of colonial views of what families are supposed to be and how they are supposed to function.*

4. Results[2]

A. Survey Results[3]

Survey Demographics

Of the 119 participants who completed the survey, 92% (n=109) identified as First Nations and 7% (n=8) identified as Métis. The Vancouver Island Health Authority had the majority of participants, comprising 88% (n=81) of the total. Meanwhile, 10% (n=12) lived in the Northern Health region, 4% (n=5) in the Interior Health region, 5% (n=6) in the Fraser Health region, and 11% (N=13) in the Vancouver Coastal Health region. Ninety percent (n=107) of survey respondents identified as female, while 8% (n=9) identified as male, 2%

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[2] Respondents sometimes confused different insurance/government programs. Perceptions of previous processes or different programs may have influenced some opinions. This is discussed further in section 4B.

[3] Survey numbers may not add to 100% due to rounding. Categories may have been grouped together to understand broader trends (e.g., how many people answered positively vs. negatively). Percentages and 'n', the number of participants who gave that response, have been reported.

(n=2) as Two Spirit and 1% (n=1) as non-binary. Over 70% (n=86) of respondents reported living off reserve, while 30% (n=33) stated that they lived on reserve. Most respondents (80%, n=95) had some form of post-secondary education.

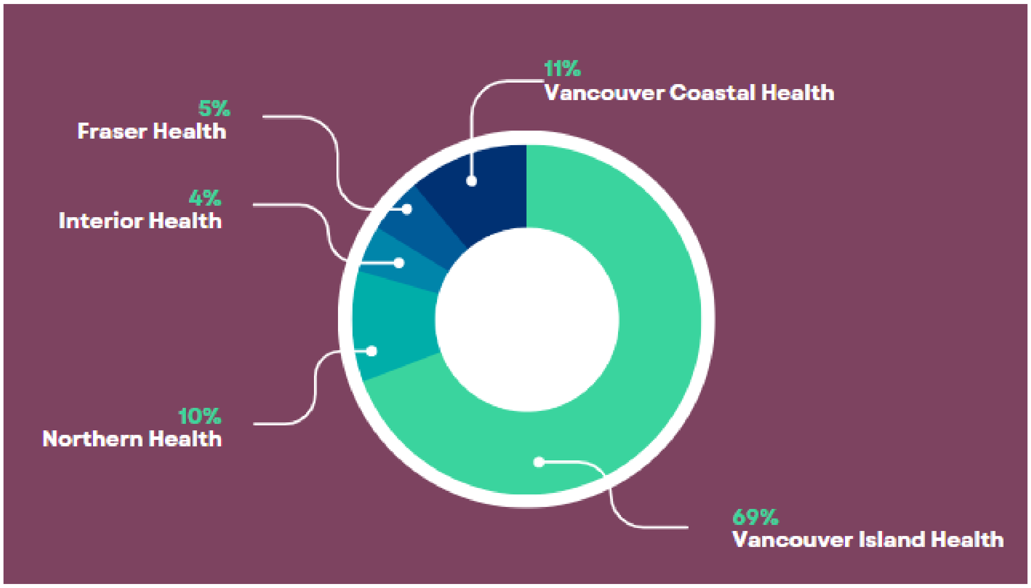


Figure 4: Location of survey respondents

Survey Results: Healthcare Experiences in the Past Year (2019-20)

Approximately 72% (n=86) of survey respondents indicated that they had visited healthcare professionals 10 times or less over the past 12 months. The majority of participants had visited both physicians (84%, n=100) and pharmacists (71%, n=84) in the previous year. Over the past 12 months, 74% (n=88) of respondents had paid out-of-pocket for OTC medications that should have been covered for them. The cost of these OTC medications for the majority of respondents, 79% (n=94), was over $20. Allergies (53% [n=63]) and chronic pain (34% [n=41]) were the most common chronic health conditions amongst the survey respondents. In the past 12 months, 75% of participants (n=91) had used an OTC prescription at a pharmacy 10 times or less over the past year.

Survey Results: Barriers to Using Insurance

Indigenous survey respondents’ top three answers when asked specifically about the reasons for not having OTC medications paid for through benefits were:

i) Their pharmacist not knowing about the program (39%, n=44)
ii) Not having the appropriate documents (20%, n=22)
iii) The process being too complicated (17%, n=19)

When asked generally about the barriers to accessing OTC medications, the top responses were:

i) Lack of information (74%, n=87)
ii) Lack of trust in the healthcare system (58%, n=69)
iii) Lack of coverage for the needed medications (53%, n=63)
iv) Felt healthcare provided was inadequate (52%, n=61)
v) Discrimination and prejudice (47%, n=56)
vi) Unavailability of doctors and/or nurses to provide prescriptions (46%, n=54)

The greatest barrier to those living off reserve and on reserve was lack of information about accessing over-the-counter prescriptions. Respondents from most health regions also listed this barrier as the most common. However, respondents off reserve in the Northern Health region listed discrimination/prejudice as the most common barrier.

Eight-five percent (n=101) of respondents had regular access to transportation. The majority of survey respondents (85%, n=102) also indicated that they had regular access to a personal computer.

B. Interview Results

Interviews with Indigenous Participants

In interviews conducted with Indigenous community members, the following themes were most frequently found:

i) Lack of awareness of FNHA Plan W, by Indigenous individuals and healthcare providers
ii) Lack of information about FNHA Plan W and difficulty understanding how the coverage process works
iii) Difficulties with healthcare providers communication and relationship building
iv) Coverage/paying out-of-pocket can depend on the specific pharmacy/pharmacist (burden of advocating for coverage if pharmacist is not helpful/harmful)

Other themes mentioned include: lack of trust/negative experiences with the healthcare system; lack of coverage for specific medications; and inadequate provision of healthcare.

Lack of Awareness

One of the most frequently expressed themes in interviews was the perceived lack of awareness about insurance programs that can cover the cost of OTC medications. Indigenous participants felt that there was a lack of awareness of programs both amongst healthcare professionals (including those that work with Indigenous populations already) and amongst Indigenous people in BC more broadly. Two of the ten Indigenous interview participants were not aware they could have OTC medication costs covered:

> *I just assumed that everyone had the same healthcare. I didn't realize that Plan W was a specific thing I was covered under. ...'Cause there wasn't many resources extended to educate me about all the things that were encompassed within Plan W. So it was basically just all like self-research. [Anonymous Indigenous Participant]*

> *...She [a healthcare professional] suggested that, you know, I get some over-the-counter relief just to make me a little bit more comfortable at home. And I was like, okay, well, you know, send someone to the pharmacy with my bank card. And she was like, oh no,*

> *there's like a whole list of things that you can get over-the-counter at no cost. And I was like...What? [Anonymous Indigenous Participant]*

> *[I] ...live and work on [a] reserve and...never heard of anyone speak of this program. [Anonymous Indigenous Participant]*

Indigenous interview participants reported that some health care providers, including physicians and pharmacists, lacked awareness of FNHA Plan W entirely. One participant described an experience of educating a physician working on reserve. In some situations, Indigenous interviewees described educating/arguing with health care providers about the existence of coverage for OTC medications:

> *They [health care providers] say, "Oh, this is not covered". And I have to try to explain as a health manager, yes, it is covered. "No, it's not covered". So is it worth it to sit there and argue the fact that is covered? When I know it's covered, but yet they don't always cover? It's not worth it really to argue with a pharmacist that, for one thing is not going to be very nice and say no, this is not covered through FNHA. ...People just give up, they get tired of it, you know? Frustrating, it's really frustrating. [Anonymous Indigenous Participant]*

> *And I said [to the pharmacist], this is a thing, you should actually print it and have it accessible to your staff and your staff should be made aware of it. It shouldn't be this hard. [Anonymous Indigenous Participant]*

Lack of Information and Difficulty Understand the Coverage Process

Another commonly expressed theme was the perception of a lack of accessible information about FNHA Plan W and insurance programs that cover OTC medications (for example, how do individuals access medications, how do they know which ones are covered, what documentation is needed, is a status card needed, is a doctor's prescription needed):

> *...I'd say over-the-counter services tend to get difficult if I'm not going to the same pharmacy... [Anonymous Indigenous Participant]*

> *...I don't ever show my status card, I don't think? Would they have that information on my file, when they bring my medical number to know that I'm or would just come up with uncovered by Blue Cross or whatever else? [Anonymous Indigenous Participant]*

> *...that list of things that are available over-the-counter is not common knowledge, there's not an awareness about it and there's not the information. [It] isn't being put out there in a way that it reaches people. [Anonymous Indigenous Participant]*

When participants were aware of FNHA Plan W, some felt that the information did not provide enough clarity about important details of the program, and that the information could be made more readily available in all locations, including on reserve health centres and pharmacies off reserve.

In some interviews, lack of awareness, lack of information, and difficulty understanding the coverage process contributed to confusion about the different provincial and territorial insurance programs that exist to cover OTC medications. This led to some feedback of FNHA Plan W being based around procedures that are no longer in place. Despite this, in some cases, such perceptions affected individuals' perceptions of newer iterations of insurance programs. For example, in the past, participants had to obtain a prescription from a physician or nurse practitioner to access coverage for OTC medications, a protocol that is no longer in place. Some participants discussed additional barriers that this created, such as adding wait times, travel time, and costs to that might prevent or delay coverage. Some participants identified changes to coverages as a barrier to accessing benefits, while others expressed a feeling of lack of clarity around coordinating coverage between plans:

> *...If I'm calling FNHA to kind of figure out what's covered and how much of a percentage are willing to do, it's really hard to figure out what kind of conversations they're having with my insurer, and then having them get back to me. So...it's just...really hard to answer sometimes in how I'm able to coordinate benefits. [Anonymous Indigenous Participant]*

A few participants noted that other variables affect how easily Indigenous people can take advantage of benefits through FNHA Plan W. For example, one participant noted that internet access and use of technology can impact how well Elders or older Indigenous people can access benefits; younger generations can be important for helping those without a computer or internet access benefit from coverage programs.

Difficulties with Healthcare Providers

Some participants discussed difficulties communicating and relationship-building with health care providers, specifically, that poor communication skills or lack of cultural safety skills on the part of health care providers hindered patient/client relationships. In addition, issues were reported with communication when healthcare professionals used technical language:

> *And that's where I always tell the pharmacists or the doctors, please do not use medical term words. They don't understand what you're saying. Make it simple, straight, you know? [Anonymous Indigenous Participant]*

Participants reported a lack of communication and miscommunication, where in some cases they felt pharmacists wanted them to pay instead of dealing with the coverage. Some participants felt neglected or ignored/pushed away:

> *Some people have difficulty trying to explain why they need maybe regular Tylenol like, and I have had a few people from the community state that the pharmacist wasn't very nice to them. You know? And they felt bad by getting a prescription because they feel like they're addicted to a drug when it was just prescribed to them maybe once or twice. [Anonymous Indigenous Participant]*
>
> *You get to learn that between you and your clients, even though you're a pharmacist, you learn to trust our people, learn to trust their pharmacists. But when the pharmacist is ignorant, or you could tell has an attitude or stuff, they don't want to go there. They don't even want to deal with it. [Anonymous Indigenous Participant]*
>
> *I'm just gonna buy it, because I've been given grief before, with pharmacists, you know, about different situations. And I was like, just feeling like, you know, I don't, I want to experience it today, I don't want to experience the prejudice, or the racism today, I'll just ******* buy the ****. And you know, I'm not even going to deal with them. But then, you know, when you're buying this stuff on the regular, and you're paying like $12, or, you know, $15, or whatever, it just adds up. And so, I was like, okay, well, let me give this*

> *a try. And I said, you know, I would like, either some Tylenol or Advil, you know, I am First Nations, I do have a prescription here. My daughter does have a prescription here for different things, but I know that there's some sort of program or something that, you know, I can get these pain medications free. And the lady at the cashier was like, I've never heard of that. And I'm like, no, it's a thing. Check. And she was like, but I've never heard of that. And I said, I'm not gonna argue with you. It's a thing. What's the program called? I said, I don't know what the program's called. But I know that there's a whole list of medications that indigenous people can access for free. And she was like, for free. Nobody gives anything away for free... [Anonymous Indigenous Participant]*

One participant discussed how some community members education was hindered by the residential school system, and thus some have challenges reading and comprehending insurance materials and have difficulty trust the health system. This impacts whether and how individuals take advantage of OTC benefits.

Experiences of Racism and Discrimination

Linked to communication difficulties were reports of racism and discrimination by pharmacists' and healthcare professionals when participants were trying to obtain coverage for OTC medications. Some participants expressed that they experienced a hesitancy to use the FNHA Plan W benefits due to the internalized stereotype that Indigenous people "get handouts." One participant described a situation in which a customer at the pharmacy commented while the participant was advocating for their right to access coverage:

> *Just pay for it, you guys are all about getting stuff for free, just pay for it... [Anonymous Indigenous Participant]*

Other participants shared experiences of racism from health care providers while trying to access care, noting that this is a reason they avoid using benefits through FNHA Plan W:

> *Or is it worth the stress for me to ask him [the health care providers] for something? I mean, I might as well just...pay for it, because then you know, the judgment that comes with it and the questions and all the above. [Anonymous Indigenous Participant]*

Interview participants expressed it is the responsibility of health care providers to create a safe environment for Indigenous people so that they are encouraged to access benefits through FNHA Plan W. Many participants expressed that accessing this government funded program felt like a fight or battle, and for those who could afford to pay for their OTC medications out-of-pocket, accessing benefits through FNHA Plan W was sometimes not worth the negative experiences:

> *I went to a doctor, and I wanted some allergy pills…He said, "Absolutely not."…And then…he made some very racist remarks around…Aboriginal people getting free prescriptions. And I wasn't strong enough to voice my opinion to him, I was really floored that he would actually share that…And…I was so shook. So, every time I went to my doctor, after that, I always had kind of, like, as fearful to ask for anything. [Anonymous Indigenous Participant]*
>
> *That stops people from accessing those over-the-counter medications as well that stigma and that you know, racist and prejudiced view of y'all getting everything for free. It stops people I know it does." [Anonymous Indigenous Participant]*

Coverage/Paying Out-of-Pocket Can Depend on the Pharmacy/Pharmacist

Many interview participants noted that whether or not individuals received coverage for OTC medication can depend on the pharmacist or pharmacy. If pharmacists or healthcare professionals are helpful, communicative, informative, and there is a good existing relationship, then individuals are more likely to be successful in receiving coverage. If the opposite is the case, then the burden of advocating for oneself and receiving coverage falls on the Indigenous individual. Some participants also described situations where health care providers provided extra support so that individuals could have medications covered where they didn't know that was possible. At the same time, participants described many negative experiences, and felt that pharmacists are not forthcoming in providing information about insurance programs that can cover the costs of OTC medications. Some participants felt they had to educate health care providers in order to get access to benefits; this is especially challenging when participants themselves felt that they did not understand enough about FNHA Plan W to do so. Participants described the dilemma of choosing between a frustrating experience advocating for themselves and FNHA Plan W, or choosing to pay out-of-pocket to avoid conflict or unpleasant situations:

> *And I said, this is a thing, you should actually print it and have it accessible to your staff and your staff should be made aware of it. It shouldn't be this hard. And they gave me the Tylenol, but then…it was such an ugly experience that I went home. And you know, won't lie, I cried. [Anonymous Indigenous Participant]*

Another participant explained that these battles with health care providers begin to add up, which can lead to Indigenous community members feeling so defeated that they give up:

> *I'm just gonna buy it, because I've been given grief before, with pharmacists, you know, about different situations. And I was like, just feeling like, you know, I don't, I want to experience it today, I don't want to experience the prejudice, or the racism today… [Anonymous Indigenous Participant]*

Interviews with Pharmacists

In the interviews conducted with pharmacists, the following themes were most frequently found:

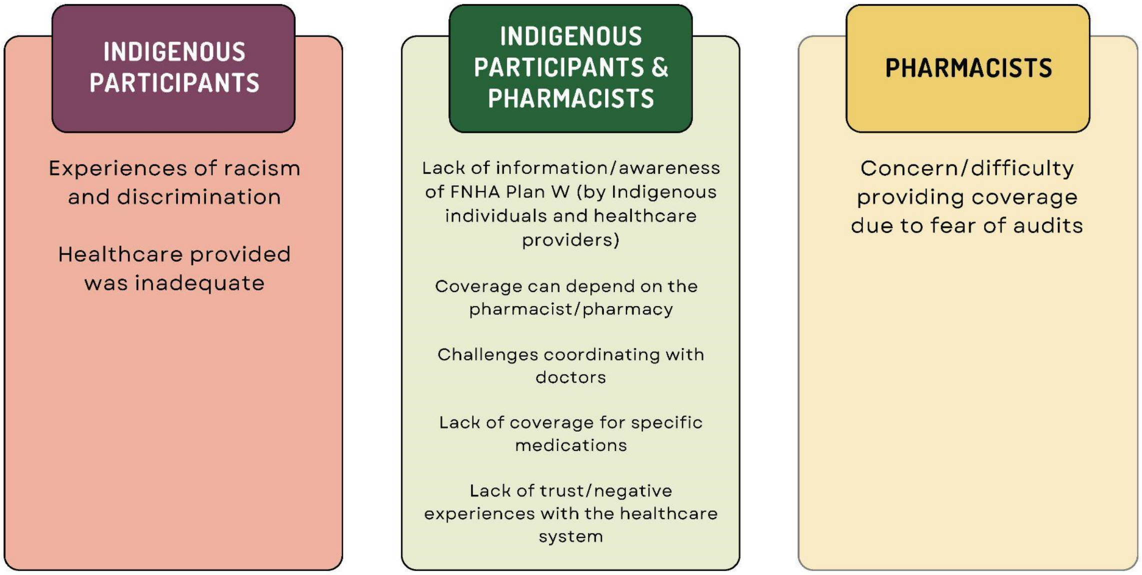
i) Lack of awareness of FNHA Plan W, by Indigenous individuals and healthcare providers
v) Lack of information about FNHA Plan W and difficulty understanding how the coverage process works
vi) Difficulties with (other) healthcare providers
vii) Experiences of racism and discrimination
viii) Coverage/paying out-of-pocket can depend on the specific pharmacy/pharmacist (Many pharmacists are spending time looking for information/specific medications to provide the best/least costly coverage)

Other themes mentioned include: difficulties providing coverage when eligibility requirements not met by the client; concerns about the potential for audits when administering medications through FNHA Plan W, making pharmacists potentially hesitant to share information FNHA Plan W; and Indigenous individuals' negative experiences of the healthcare system impacting their use of benefits. Unlike with Indigenous interview participants, this last theme was only mentioned once in interviews with pharmacists.

Many of the themes from pharmacists' interviews were held in common by Indigenous participants (see Figure 5). Unlike Indigenous interview participants, all pharmacists interviewed were aware of FNHA Plan W to cover OTC costs for Indigenous people. All but one pharmacist had used/knew how to use the FNHA Plan W system and provide coverage to clients.

While pharmacists generally agreed that some barriers exist, the majority of pharmacists stated that providing coverage to Indigenous clients through FNHA Plan W is not too difficult most of the time:

> *…There's no barrier. …Talking about my pharmacy specifically, we try and do everything we can to help everybody get everything covered, if possible… [Anonymous Pharmacist]*
>
> *I wouldn't say there has been any difficulties… [Anonymous Pharmacist]*
>
> *…The computer does all the work, right? So basically, as long as we have a DIN number in our pharmacy, and it's a DIN number that they cover, which is on the list, it's pretty straightforward. [Anonymous Pharmacist]*
>
> *Difficulties? None except, you know sometimes billing issues can be an issue, but I think that has been resolved to some extent. But there were a few changes that happened in the billing processes two years ago. So, you really didn't know, you'd bill one place, and they'd turn it down, and it was "Oh no, they moved over to First Nations something like that, then you had to go and sort of make sure they're registered and sometimes they weren't registered etc. but that's mostly now been sorted out. [Anonymous Pharmacist]*



INDIGENOUS PARTICIPANTS

- Experiences of racism and discrimination
- Healthcare provided was inadequate

INDIGENOUS PARTICIPANTS & PHARMACISTS

- Lack of information/awareness of FNHA Plan W (by Indigenous individuals and healthcare providers)
- Coverage can depend on the pharmacist/pharmacy
- Challenges coordinating with doctors
- Lack of coverage for specific medications
- Lack of trust/negative experiences with the healthcare system

PHARMACISTS

- Concern/difficulty providing coverage due to fear of audits

Figure 5: Interview themes found within interviews with Indigenous respondents and pharmacists

Lack of Awareness

All pharmacist interview participants expressed that many Indigenous clients are not aware that OTC medications can be covered by FNHA Plan W:

> *...a lot of people are surprised when we mentioned, 'Oh, you know, we can do this, it'll be covered for you. [Anonymous Pharmacist]*
>
> *I don't think it's been communicated to them [Indigenous individuals] well...they understand if they get a prescription from a doctor, that there's an expectation that's covered that I don't think many know that they can walk into a pharmacy and request something from the pharmacist and have it covered. I think that needs to be communicated to the client and the providers. [Anonymous Pharmacist]*
>
> *...One of the things that I've noticed is the Indigenous people aren't aware of that possibility, that they can actually get, you know, from pharmacists don't need a doctor's prescription. [Anonymous Pharmacist]*

Lack of Information and Difficulty Understand the Coverage Process

Interviews with pharmacists also identified a perceived lack of information shared about key details of coverage for OTC medications. However, opinions were divided on the ease of using the FNHA Plan W system: some pharmacists felt that information about the coverage process for FNHA Plan W and other insurance programs (i.e., which medications are covered, who/how to bill for each client) is not always clear, while others felt it was simple:

> *"...A lot of times like the actual process of billing, it can be very confusing." [Anonymous Pharmacist]*
>
> *"The billing process is fairly simple and online." [Anonymous Pharmacist]*

Some pharmacists felt that information about medication coverage was difficult to find, and that inconsistent information was provided. For example, some pharmacists reported difficulties coordinating coverage, and noted that information on the partner organizations such as Pacific Blue Cross have websites that appear scattered and disorganized, making it difficult to access and navigate and adding time:

> *...When I talk to patients who travelled down island or other parts of BC, where maybe the First Nations population isn't as high, there doesn't seem to be the same awareness. And I think it's probably because the information is spread out, you know, on the FNHA website, or on the Blue Cross website, or on the Pharmacare [website], where there's pieces of it everywhere... It can be confusing... [Anonymous Pharmacist]*
>
> *I think one of the biggest ones would be who would be the payer. That's oftentimes the biggest challenge. And sometimes we're working with a social worker that works with a specific patient that needs something covered. And they might be paying out-of-pocket and then it goes through different expenses, as it doesn't belong to the formulary with Pacific Blue Cross coverage. [Anonymous Pharmacist]*

Some pharmacists interviewed felt that a lack of information about FNHA Plan W coverage was frustrating and required them to do extra work. This lack of information means that when processing drugs, pharmacists must do additional work researching different websites to determine whether the drug is in the formulary, which can be time consuming. Other inconsistent information includes the coverage lists not being up to date, which can cause issues with coverage benefits. Many of the pharmacists also mentioned that the coverage could be narrow, as only one brand for a certain medication would be covered:

> *…some products, only certain brands are covered, even though there's an equivalent thing, so you have to kind of have to figure out what's the brand they're looking for. [Anonymous Pharmacist]*

This narrow coverage became even more of an issue during the pandemic, as there were shortages on certain brands that were covered:

> *Another thing is that, for coverage, it's only specific brands that are covered. Not all brands of a specific medication are covered, for example, acetaminophen, it will only be from these, like four suppliers, that it will be eligible for coverage. And then everything else is not eligible for coverage, even though it is the same medication. And that can be really frustrating, especially when, during COVID, for example, there were a lot of drug shortages, so medications were just not available. [Anonymous Pharmacist]*

Difficulties with Other Healthcare Providers

Interview participants largely agreed that the change to pharmacist-generated recommendations makes it easier for coverage to be obtained for OTC medications. Bypassing the prescription can create fewer barriers, especially with shortage of family doctors in BC and COVID circumstances. However, a few pharmacists noted that there are still some cases where important for doctor to be involved, and that every case is different.

In addition, as with Indigenous interviews, some feedback of FNHA Plan W was based around procedures that are no longer in place. Regardless, many pharmacists commented that doctors are often not aware of FNHA Plan W/insurance programs to cover OTC medications when writing prescriptions, lack knowledge of which medications are covered, and sometimes prescribe things that do not align with FNHA coverage:

> *I'm sure they [doctors] could be doing more. I think they don't. A lot of them don't think about over-the-counter stuff as much and I don't know how aware they are that some of their patients can have these things provided to them as covered.... in general, I think most doctors don't pay much attention to what is or isn't covered. [Anonymous Pharmacist]*
>
> *...First of all, doctors don't really have-they don't know the list of what's covered, what's not covered. ...They can't seem to access as easy as we can and so then that becomes an issue, because then, of course, the coverage of that medication now is dependent on us after. Like, refilling it, basically the whole responsibility now falls on us when we receive the prescription as to how we're going to help that client, right? [Anonymous Pharmacist]*
>
> *I think a lot of the times there's disconnect between maybe the conversation happening in a physician's office, and then the conversation that happens in the pharmacy. [Anonymous Pharmacist]*

Physicians' lack of awareness and knowledge about coverage can cause delays to client treatment and clients paying out-of-pocket to avoid delays. Some pharmacists interviewed mentioned that physicians may not always follow appropriate procedures for prescribing OTC medications to Indigenous patients (e.g., writing prescriptions on sticky notes, which cannot be processed or billed to an insurance plan). Other pharmacists reported that physicians have prescribed drugs outside of the scope of coverage for clients. When pharmacists do not receive the correct documentation, they report having to do extra work to make the medication accessible to the client, such as reaching out to doctors themselves to get the prescriptions changed or determining how the prescription should be changed so that they can provide the medication to the client with coverage:

> *Prescribers sometimes don't fill out a prescription completely...Sometimes we do have to get clarification on, for example, the dose or the directions for use if it's not included on*

> *the prescription, which, again, can cause a delay because we're waiting for the prescriber to get back to us. [Anonymous Pharmacist]*

Even though prescribers sometimes present a barrier to accessing benefits through FNHA Plan W, some pharmacists interviewed still felt it is important that physicians are involved in the process of approving OTCs. The main reason presented was that pharmacists cannot act as the physicians, making any type of major assessment or diagnosis. Other pharmacists interviewed believed that FNHA Plan W benefits should be pharmacist-initiated. Their reasons included that since few physicians know what is covered, pharmacists should be able to approve the extension of a drug, and that it currently ends up being more work on the pharmacist to figure out how to help their clients when physicians make mistakes. Another reason mentioned was that it increases ease of access for Indigenous clients:

> *If we can remove some of the steps in terms of patient getting care then and speed up the process and patient gets the resolution quicker, then I think it's worthwhile just having the pharmacist prescribe it. [Anonymous Pharmacist]*

A few pharmacists shared that they felt a lack of communication from health care providers to patients about FNHA Plan W may be due to lack of education or training about such benefits in medical and pharmacy school. One recent pharmacy school graduate reported that they were not educated on FNHA Plan W during their education, and that they did not know where to find information about the program:

> *And it was never really taught in school. And as…a new grad I don't even really know too much about where I can get more information, but I wish that I did. [Anonymous Pharmacist]*

Coverage/Paying Out-of-Pocket Can Depend on the Pharmacy/Pharmacist

As with Indigenous participants, many pharmacists interviewed also discussed how whether or not Indigenous individuals receive coverage for OTC medications or pay out-of-pocket can depend on the specific response of the pharmacist/pharmacy. Unlike with Indigenous participants however, there was more of a focus on examples of pharmacists going out of their way to provide information.[4] Many pharmacists interviewed noted they are spending time looking for information/specific medications to provide the best/least costly coverage:

> *…the pharmacy plays a role. You know, if you have a good pharmacist who actually will remind them to get a prescription for something that they don't need to be paying for, that's great. But if you have someone who maybe is too busy or doesn't necessarily know, then that person may end up spending more money for something that they shouldn't have been paying for in the first place…. I definitely would say pharmacists have at least an ethical obligation to our Indigenous clients. …If they are eligible to have something, you know, that they don't have to pay for, why would you want them to pay for it? [Anonymous Pharmacist]*
>
> *I'm not sure they're aware of that program [Plan W]… People ask because I've been here a long time, 15 years… and then I point out, hey, this is covered and, and we'll go from there. But there's very few people [that] ever approached the counter, unless I've interacted with them before that. …There's definitely a general unawareness amongst the clients to have what, you know that they can get things without a doctor's prescription. So, I have to say, I've always got my eye out there, and just to pointed out to people. …[It] comes down to communication. [Anonymous Pharmacist]*
>
> *I think a lot of it is just the prejudice people have when someone walks in… [When] anyone comes to our pharmacy, we have to treat them just like any other patient, and we do our best to make sure they get the medication they need. …We'll go the extra mile regardless of if they're Indigenous or non-Indigenous to make sure they're getting the medication they need… [Anonymous Pharmacist]*

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[4] This may be affected by the study design, in that pharmacists/pharmacies less interested in engaging with the topic would likely not have elected to participate in an interview. See the limitations section for more detail.

> *I'm lucky to have somebody here that works with First Nations Health Authority as a pharmacist, and I could easily message him directly. So, I am lucky but other population, other pharmacists are not as fortunate. [Anonymous Pharmacist]*

5. Discussion

The complexities of insurance programs combined with pre-existing health disparities, previous mistreatment of Indigenous people by the healthcare system and income inequality, may limit medication access and cause further mistrust for healthcare institutions amongst Indigenous people. Limited access to medications can, in turn, increase health disparities and worsen quality of life among Indigenous communities. In this study, while many Indigenous participants knew about programs to cover the cost of OTC medications, factors and barriers existed that discouraged some individuals from accessing benefits through FNHA Plan W.

This study confirmed that the quality of the relationship between health care providers and clients is an important factor in determining Indigenous clients' experiences of the healthcare system. It can also play a role in determining whether individuals access benefits through the FNHA Plan W program. A positive relationship is beneficial to health outcomes (Chipidza et. al., 2015; Stewart 1995), yet many Indigenous participants shared experiences of facing racism and discrimination from health care providers. This is very likely contributing to a continued lack of trust in the healthcare system. Participants emphasized the importance of providing more culturally competent care for Indigenous people:

> *The cultural safety, I need to feel proud of who I am. And I don't want to have to be questioned, or feel less than, because I want some vitamins, or I want some Tylenol... [Anonymous Indigenous Participant]*

6. Recommendations

Table 1 shows the recommendations provided by study participants, and suggestions for possible action items.[5] Key recommendations include increased awareness/information about insurance program coverage details (including plain language information on provincial coverage should be shared more widely at pharmacies), and increased awareness and cultural competency/safety by pharmacy staff, healthcare providers, to reduce negative experiences.

Table 1. Participant Recommendations and Suggested Action Items.

Participant Recommendations	**Suggested Action Items (Participants and CREAN)**
Increased cultural competency by pharmacy staff and other health care providers	• Increased opportunities for Indigenous health-focused education in professional schools/education programs. • Continuing/ongoing professional development opportunities for health care providers to learn about Indigenous health • Ensure Indigenous health history is taught in professional schools so health care providers understand the history of previous mistreatment • Mandatory Indigenous-led anti-oppression training to maintain pharmaceutical and medical licenses

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[5] CREAN would like to recognize the many and valuable recommendations already put forth by Indigenous entities, such as the First Nations Women's Association of Canada factsheet on health benefits, as well as other evaluation frameworks completed (e.g., Goss Gilroy Inc. evaluation of benefits).

Increased awareness of FNHA Plan W, by health care providers and Indigenous individuals	• Increase in accessible information targeted towards health care providers • Include information in licensing boards, in BC Pharmacy Association communications, or in Pharmacare newsletters, etc. • Increase in/expansion of informational materials, such as pamphlets, that outline what the program is and how to access it • Ensure vulnerable populations within the Indigenous community are not missed by providing information to shelters and safe injection sites
Improve available information about FNHA Plan W	• Make the information more easily accessible and all in one place, so that pharmacists and Indigenous community members will not have to search multiple sites to find information • Improve the clarity of the available information about coverages and how to access the program • Ensure documents are easy to read so that Indigenous community members do not have to know medical and insurance terminology to understand

7. Potential Study Limitations

Some possible study limitations include:

- Confusion on behalf of participants between programs: NIHB, FNHA Plan W, etc. Some respondents expressed opinions about expired programs, and procedures that have been made redundant. While past perceptions are important in that they can affect current perceptions and willingness to engage, this does complicate feedback of existing benefits programs.
- Selection bias means that those that are already interested and invested in the topic are the most likely to respond. The likelihood of receiving either very positive or very negative information increases with selection bias.
- Disruptions to some research methods (e.g., focus groups) occurred during the recruitment and data collection phase, due to COVID-19. It was difficult to obtain

higher sample numbers for the interviews and survey responses due to the stress of COVID-19 pandemic on healthcare workers and Indigenous people. It took a long period of time to recruit participants, so the circumstances of accessibility which they have reported may have changed during the two years of which this study took place.

- Within the survey, there was an overrepresentation of female survey respondents, and those within the Vancouver Island Health Authority region. Overrepresentation of females among survey respondents is a common trend in many different types of surveys, including telephone, mail, and online surveys (Rourke & Lakner, 1989; Whitaker et al., 2017; Alba et al., 2019). More research to consider other opinions and demographics may be an important step.
- Most participants in this study indicated that they had come across the survey on Facebook, demonstrating it to be the most effective recruitment method for this study. While Facebook is useful for reaching many populations, it may have excluded participants who are not on Facebook or not used to using it, or do not have access to internet/computers/email/social media (e.g., potentially some Elders, those in more remote communities). Populations that do not have access to the internet or phone could not be reached or surveyed in our sample.
- There could be several unique challenges for individual Indigenous nations that are not captured by this study. Indigenous participants discussed their experiences and struggles within their own community, which cannot be generalized to all Indigenous communities in Canada. It is important to note the diversity of Indigenous communities and avoid homogenizing Indigenous groups’ problems as they are not representative of each individual nation or community’s struggles.
- Some issues regarding accessibility due to geographical distance to reliable pharmaceutical care could be under-reported considering that our survey and interview populations were mostly urban.

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Appendix A – Resources

KUU-US Crisis Line Society: First Nations and Aboriginal specific 24/7 crisis line based in Port Alberni and serving the entire province.

- Toll-free: 800-588-8717
- Youth Line: 250-723-2040
- Adult Line: 250-723-4050

Native Youth Crisis Hotline: Answered by staff 24/7. Available throughout Canada and US.

- 877-209-1266

WAVAW Indigenous Counselling: Call for crisis support, or to register for counselling or support groups. Offering one-to-one counselling using a holistic approach utilizing traditional teachings. Support groups from an Aboriginal perspective. Healing Circles and Pipe Ceremonies. Traditional Indigenous teachings. Community referrals. Information regarding colonization and residential school generational affects.

- 604-255-6344

Prince George Native Friendship Centre: The Native Healing centre offers holistic and culturally sensitive programs to Aboriginal and non-Aboriginal people who have been affected by trauma, addictions, or grief and loss.

- 250-564-3568
- http://www.pgnfc.com/

Victoria Native Friendship Centre: Provides counselling services for Indigenous people. Intake Hours: Monday to Friday 1-4pm.

- 250-384-3211
- http://www.vnfc.ca

The Support Network for Indigenous Women, Women of Colour: Free and sliding-scale therapy sessions for low-income racialized women.

- https://www.sniwwoc.ca/mental-health

Healing in Colour: Provides therapy services for Black, Indigenous, and people of colour and well as a directory of Black, Indigenous, therapists of colour.

- https://www.healingincolour.com/directory