The Real Cost Of Cutting The Interim Federal Health Program

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The Wellesley Institute engages in research, policy and community mobilization to advance population health.

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TABLE OF CONTENTS

Introduction
Changes To The Interim Federal Health Program
Applying A Health Equity Lens
Tracking The Impact Of Changes To The Interim Federal Health Program
Scoping Analysis Of Changes To The Interim Federal Health Program
How Changes To The Interim Federal Health Program Have Affected The Health Of Refugees
Basic Health Benefits
Urgent And Essential Coverage
Emergency Room Use
Administrative Complexity
Care For Women And Children
Changing The Interim Federal Health Program To Protect And Promote Good Health
Equity Indicators And Objectives To Determine The Impact Of Changes To The Interim Federal Healt
Program9
Action Required: Federal Government
Action Required: Provincial And Territorial Governments10
Action Required: Regional Health Authorities And Health Care Providers1
Involving Refugees In Planning And Designing Policies That Affect Their Health1
Conclusions12
Changes To The Interim Federal Health Program Have Inequitable Health Implications For Refugee
And Claimants12
Summary Of Actions Required12
Federal Government12
Provincial And Territorial Governments12
Regional Health Authorities12
Health Care Providers12
Appendix I: IFH Coverage Categories And Eligibility By Refugee Status1
Appendix Ii: Wellesley Health Equity Lens18

Introduction

The Interim Federal Health (IFH) program is a temporary health insurance program available to refugees, protected persons, and refugee claimants in Canada. This coverage is similar to the level of coverage that provincial and territorial governments provide for people receiving social assistance, including coverage for prescription drugs, dental, and vision care.

Prior to June 30, 2012, IFH program coverage was available with similar benefits to all refugees and refugee claimants in Canada, regardless of their refugee category. This coverage recognized that refugees and refugee claimants have health care needs and typically lack the financial resources to purchase private health insurance.

On June 30, 2012, the federal government implemented changes to the IFH program that resulted in the effective elimination of health care coverage for many refugees and refugee claimants and reduced access to health care services for most. The new program provides different health care services to various categories of refugees and claimants. For example, government-assisted refugees retain access to health care services that are similar to the previous coverage, while refugee claimants from Designated Countries of Origin – countries that are considered by the Government of Canada to be safe – receive effectively no health services for common needs, such as prenatal care, or emergency needs, such as heart attacks. The government deems this category eligible for health services only if they pose a public health risk, which in itself, is defined very narrowly.

Prior to the changes taking effect, the Wellesley Institute completed a Health Equity Impact Assessment in May 2012, and based on the findings predicted that the health of refugees would be negatively affected by the changes to the IFH program and that some populations, such as women and children, would be disproportionately impacted. We also predicted an increase in avoidable emergency room visits, increased health care costs for provinces and territories, and increased prevalence of chronic conditions among refugee populations. Unfortunately, evidence is now mounting that these outcomes are occurring.

This updated assessment uses data collected from health care providers across Canada via an online reporting tool to demonstrate some of the negative and avoidable health outcomes that have occurred among refugee populations since the changes to the IFH program were implemented. This review indicates that the new system creates confusion, lessens access to health care services among vulnerable populations, leads to inconsistency in care across Canada, and results in poorer health and avoidable illness for refugees and refugee claimants.

Changes To The Interim Federal Health Program

In recent years, the federal government has undertaken significant reform of Canada's immigration system, with particular emphasis on addressing perceived fraud among refugee claimants. Former Citizenship, Immigration and Multiculturalism Minister Jason Kenney, who oversaw many of these reforms, argued that Canada receives a disproportionate number of refugee claimants from countries that are historically considered safe. In this context, Minister Kenney implemented changes to the Interim Federal Health program, which took effect on June 30, 2012. Under the reformed IFH program,

1

¹ United Nations High Commissioner for Refugees, Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees, http://www.unhcr.org/3d58e13b4.html.

different levels of health care coverage are provided to different refugee and refugee claimant categories, as demonstrated in Appendix I.

The differentiation of refugees by category for the purposes of determining levels of health care coverage is a significant departure from the previous IFH program. The IFH program had recognized that refugees and refugee claimants may have experienced persecution in their home country and therefore may be particularly at risk of poor health. It also recognized that providing health care coverage similar to the coverage provided by provinces and territories is an important first step toward good health and inclusion in Canadian society.

Differentiating health care coverage for refugees based on category moves away from this model. The level of coverage in each category reflects Citizenship and Immigration Canada's estimation as to whether they are a "genuine" refugee. Minister Kenney repeatedly stated that the changes to the IFH program were part of a broader effort to deter "bogus" refugee claimants. Despite repeated requests for clarification, evidence to support the need for this policy reform has not been forthcoming.

The first edition of this Health Equity Impact Assessment outlined the potential health impacts of the changes to the IFH program. Our analysis found that reducing access to the IFH program would:

- Make accessing even basic health care services difficult for all refugees and refugee claimants, even those who are in the preferred categories such as government assisted refugees;
- Result in the severe reduction or elimination of health care services for refugees and refugee claimants who are in less-preferred categories;
- Lead to increased numbers of refugees and refugee claimants arriving in emergency rooms for reasons that could have been avoided, adding to already long wait times and decreasing the quality and responsiveness of care for refugees and claimants;
- Increase health care and related costs for Provinces and Territories, who would be left to pick up the bill for these avoidable medical costs;
- Put women and children at particular risk as their access to medical support, if they suffer physical or emotional abuse, would be eliminated; and
- Increase the prevalence of chronic conditions, such as mental health issues, among vulnerable populations.

Our analysis concluded that these negative and inequitable health outcomes could, however, be avoided. We recommended that the federal government not pursue the policy changes or, at the very least, delay implementing changes to the IFH program until they completed a comprehensive Health Equity Impact Assessment (HEIA). In addition, 21 professional health care associations from across Canada expressed concerns or recommended that the federal government cancel the changes to the IFH program.³ To date the federal government has not accepted this advice.

This HEIA builds on our initial analysis, but it focuses on the actual adverse health outcomes of refugees and claimants that have resulted from the changes to the IFH program.

² Citizenship and Immigration Canada has a two-step process for determining whether a country is designated as safe: 1) a rejection rate of 75 percent or higher for refugee claims and/or an abandonment/withdrawal rate of 60 percent of higher, and 2) a review of whether the country has an independent judicial system, recognizes democratic rights and freedoms, and has civil society organizations. See Citizenship and Immigration Canada, Backgrounder: Designated Countries of Origin, 2012. <a href="http://www.cic.gc.ca/english/department/media/backgrounders/2012/2012-02-16i.asp.these criteria and the concept of 'safe' countries have been criticized for failing to recognize that not all populations are safe even within countries that are safe for most of their citizens. The Roma population in Hungary and LGTB populations in many countries have been cited as key examples. See N. Alboim and K. Cohl, Shaping the Future: Canada's rapidly changing immigration policies, Maytree Foundation, October 2012.</p>

³ A full list of the 21 professional health care associations can be found at http://www.doctorsforrefugeecare.ca/show-your-support.html.

Applying A Health Equity Lens

Policy decisions made far beyond the health care system can have significant health implications. Decisions about housing, income, education, or other underlying determinants of health can create negative health outcomes that affect the population as a whole, but vulnerable or marginalized populations are often more severely impacted than other groups. It is therefore important to consider health and health equity when making policy decisions that may affect the determinants of health.

HEIA is a tool used to analyze a new program or policy's potential impact on health, health disparities and/or on health disadvantaged populations. A simple health equity question should be applied to all policy decisions: could the proposal have an inequitable impact on some groups, and, if so, which groups would be disproportionately affected? If there could be a health impact, a fuller HEIA then helps policy-makers and planners to make changes to the planned policy to mitigate adverse effects on the most vulnerable and to enhance equity objectives. Finally, the HEIA tool assists in setting targets and measurements to determine the policy's success.⁴

Tracking The Impact Of Changes To The Interim Federal Health Program

Best practices within public policy show that it is important to monitor and evaluate the impact of policy or program changes to ensure that the policy goals are being achieved and that any negative unintended consequences can be mitigated or eliminated. In our initial HEIA we recommended that, if the federal government proceeded with the IFH program cuts, they should incorporate measurement and evaluation into their reforms to ensure that the health of refugees and refugee claimants was not being negatively impacted. There is no indication that the government undertook such an analysis.

Health care providers across Canada have, however, undertaken an initiative to identify and document the impact of reforms to the IFH program. Canadian Doctors for Refugee Care are working with health care providers across disciplines to track the impacts of changes to the IFH program using the Refugee Health Outcome Monitoring and Evaluation System tool (Refugee HOMES). The Refugee HOMES tool is a simple online survey that is completed by health providers when they care for refugees. The survey, which was launched when the IFH cuts took effect, records information on:

- · Age
- Gender
- Immigration status
- The condition most responsible for any adverse health outcome
- The result of the adverse outcome (e.g. decreased functioning, avoidable emergency room visits, or acute mental health crises)
- A description of the adverse outcome and the severity of the impact
- · Whether the adverse outcome could have been avoided
- · A narrative description of how the adverse outcome could have been avoided

The health care provider's name, qualifications, and contact information is also collected for verification purposes. No identifying patient information is collected. All adverse outcome cases are verified for accuracy.

3

See Rebecca Haber, Health Equity Impact Assessment: A Primer, The Wellesley Institute, 2010, for a summary of HEIA. The Wellesley Institute has a range of Health Equity Impact Assessment tools and resources, which are available at http://www.wellesleyinstitute.com/policy-fields/healthcare-reform/roadmap-for-health-equity/heath-equity-impact-assessment/. The Ontario government has developed a HEIA tool: http://www.torontocentrallhin.on.ca/Page.aspx?id=2936.

This methodology is not designed as a systematic survey of patient outcomes and we cannot draw conclusions from individual cases or know how representative these cases are of the range of refugee health experiences. However, collecting front-line information and data from health care professionals can help to assess whether there have been health effects of the IFH program changes and to identify the nature of these impacts on the health of refugees across Canada. There is currently no evidence available on the long-term effects and health trajectories of refugees and refugee claimants who have been affected by the changes to the IFH program, although this will be addressed over the next three years by a collaborative research project between the Centre for Research on Inner City Health, the Hospital for Sick Children, Montreal Children's Hospital and McGill University. However, the information collected by the Refugee HOMES tool provides enough preliminary data to begin to evaluate the impacts of the changes to the IFH program. The information and data that this paper draws from was submitted by health care providers across Canada via the Refugee HOMES tool between July 2012 and August 2013. The patterns from these case reports are consistent and clear: the predicted adverse health-related impacts are occurring.

Scoping Analysis Of Changes To The Interim Federal Health Program

Policy-oriented HEIAs follow a straightforward series of stages in determining potential health and health equity impacts, which are set out in Appendix II. The first stage is an initial scoping analysis of whether the policy change has health equity impacts:

- 1. Could the planned policy, budget decision, program or initiative impact overall health, either by affecting employment, income, housing or other determinants of health, or by affecting access to health, social and other services and support?
- 2. Could the planned policy, budget decision, program or initiative have an inequitable impact on particular groups or communities? If so, which people or communities?

This is intended to identify whether there are possible impacts – positive or negative – that need to be considered in more detail.

Canadian and international evidence shows that vulnerable populations who lack health insurance:

- Delay or forgo seeking health care, including emergency services, prenatal care and treatment for infectious diseases;
- Are often denied care by health care providers when it is sought; and
- Are sometimes discriminated against when care is sought.6

As a result, this can mean higher rates of infectious diseases, more serious triage assessments in emergency rooms, higher rates of complications in pregnancy, newborn anomalies, greater exposure to hazardous and preventable conditions, and negative mental health consequences.⁷

Refugees typically experience several forms of threats before arriving to their host country, including threats to life or freedom on account of race, religion, nationality, political opinion or membership of a

⁵ Centre for Inner City Health, Accessibility and costs of health care for refugee claimants following changes to the Interim Federal Health Program, http://www.stmichaelshospital.com/crich/projects/accessibility-and-costs-of-health-care-for-refugee-claimants-following-changes-to-the-interim-federal-health-program/.

⁶ See, for example, J. Hadley, "Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income", Medical Care Research and Review, Vol. 60, No. 2, June 2003, pp. 3S-75S; P. Caulford and Y. Vali, 'Providing health care to medically uninsured immigrants and refugees', Canadian Medical Association Journal, Vol. 174, No. 9, April 2006, pp. 1253-1254;

⁷ See Bob Gardner, "Driving Health Equity for Refugee and Immigrant Populations: Policy Actions Needed", http://www.wellesleyinstitute.com/news/driving-health-equity-for-refugee-and-immigrant-populations-policy-actions-needed/.

particular social group. Refugees may also experience persecution based on sexual orientation or gender. In our initial assessment, we argued that as a consequence of this persecution, they may be at greater risk of adverse health, especially mental health conditions.

Refugees are at particular risk when they are uninsured as they usually have few financial resources that would allow them to pay out of pocket for their medical care. Moreover, their uncertain legal status in Canada and their lack of networks and social connections may mean that they are less likely to be able to find support and care when it is required.

Therefore, an initial scoping analysis of the cuts to the IFH program shows that there are important health equity impacts to consider.

How Changes To The Interim Federal Health Program Have Affected The Health Of Refugees

Basic Health Benefits

In our initial analysis, we showed that the changes to the IFH program would adversely affect the health of refugees, protected persons, and refugee claimants in Canada who are not covered by provincial or territorial health insurance, and who do not have private insurance. Elimination of key health benefits, such as drug coverage, makes preventing and managing chronic conditions, such as diabetes, more difficult for refugees and claimants. A lack of access to mental health services is particularly concerning, especially given the psychological risks that many refugees face, including post-traumatic stress disorder (PTSD), depression and anxiety disorders risk that many refugees face.

The Refugee HOMES tool has recorded evidence that cuts to health benefits from IFH coverage are having several negative health outcomes for refugees and claimants. Illustrative examples include:

- A female refugee claimant who is a senior with diabetes and chronic kidney disease had her condition severely deteriorate because of lack of access to medication, regular blood testing and monitoring, and dietician care.
- Two young children with multiple hospitalizations for asthma could not get access to their inhalers, leaving them at risk for increased need for emergency department visits.
- A teenager with PTSD and previous suicide attempts who has valid IFH program coverage was cut off from essential psychiatric medications.

Urgent And Essential Coverage

The refocusing of the IFH program to only urgent and essential coverage for many refugees and refugee claimants means that access to health care providers is significantly reduced in the early stages of illness. Consequently, conditions that could be easily treated at an early stage become more serious and more costly to treat. Moreover, health promotion initiatives are almost impossible to implement owing to refugees and claimants only becoming eligible for care once they become seriously ill. This creates serious public health risks.

There are also serious contradictions within the new IFH program categories that mean that refugees and refugee claimants who are eligible only for public health coverage are not able to access care unless

⁸ United Nations High Commissioner for Refugees, *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees*, http://www.unhcr.org/3d58e13b4.html.

⁹ Canadian Mental Health Association, Ontario, Immigrants and Refugees, http://www.ontario.cmha.ca/about_mental_health.asp?cID=23054

they are known to have one of 35 conditions on the IFH "diseases of public health" list. Thus a refugee or refugee claimant would have to self-determine whether they have a particular condition before seeing a doctor and whether they would be covered for treatment. ¹⁰ This is impossible and demonstrates the incoherence of the IFH program changes.

• A male refugee claimant experiencing chest pain and having characteristics that made his physician suspicious of tuberculosis was not eligible for a chest x-ray because tuberculosis had not been diagnosed.

Emergency Room Use

There is a risk that refugees and claimants who are no longer eligible for IFH program coverage will either forego medical treatment, or will use emergency departments and incur significant medical bills that they are likely unable to pay.

- A female with asthma whose refugee claim had been accepted had an avoidable emergency room visit and hospitalization because of a lack of medication.
- A female refugee claimant with fibroids and adenomyosis had surgery cancelled due to her IFH program status. As a result, the patient had numerous emergency room visits for severe pain.
- A refugee claimant, 32 weeks pregnant, presented at two emergency rooms suffering from lower abdominal pain. On both occasions she was told that she would have to sign a document stating that she would be responsible for the costs of her visit. She left the emergency room on both occasions without being seen.

Administrative Complexity

One unexpected impact of the changes to the IFH program was the confusion and administrative complexity that health care providers continue to face in determining refugee patient eligibility. This was compounded by vague directions by the federal government, such as making unannounced changes to the new IFH policy on the Citizenship and Immigration Canada website the day before the policy took effect. In practice, clinicians had to call the insurer, Blue Cross, for every case. It would also appear that the insurer was frequently turning down requests that proved to be valid. The unfortunate outcomes of these communication and administration problems are cases where refugees are being denied care despite being eligible for IFH program coverage.

- A child with a potentially contagious rash was turned away from a clinic because her IFH program coverage, although valid, was not accepted by the clinic.
- A man with a rectal mass was turned away from care many times although he should have health insurance according to the IFH policy.

Evidence also indicates that administrative delays by the insurer in approving IFH coverage are contributing to refugees being unable to access necessary care.

- A woman claimant arrived in Canada pregnant but could not get adequate testing to monitor her pregnancy as she awaited her IFH program coverage to be implemented.
- A refugee man requiring urgent eye surgery to prevent blindness was refused IFH program coverage because he was said to be an "illegal migrant expected to leave the country." Ten days later he received notification from Citizen and Immigration Canada that he was eligible for permanent residency status.

¹⁰ The list of covered "diseases of public health" is available at <a href="https://www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blo-btable=MungoBlobs&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187212-811067&blobheader=application%2Fpdf.

¹¹ CBC News, Refugee health cuts 'clarified,' not reversed, Kenney says, July 3, 2012. http://www.cbc.ca/news/politics/story/2012/07/03/pol-refugee-health-cuts.html.

- A young girl from an area with malaria had a high fever but did not have health coverage to rule out malaria as she awaited her IFH program coverage to be initiated.
- A woman very late in her pregnancy was turned away by her regular doctor despite being eligible for IFH program coverage.

The lengthy and complicated process to get coverage approved acts as a disincentive to providers. Clinicians specializing in refugee care are concerned that some colleagues are no longer providing care to refugees because of these new administrative burdens in getting patients covered and services reimbursed.

Care For Women And Children

In our initial HEIA we showed that some populations would be at increased risk of serious health issues regardless of which official category they fit into. Women face particular risks if they are unable to access health care services, especially in cases of domestic violence or sexual assault.

- A refugee claimant, 36 weeks pregnant, was told by her obstetrician that IFH would no longer provide insurance for her pregnancy or delivery and to bring in \$3,000 for her next appointment. After weeks of anxiety and investigation, the IFH program admitted they made a mistake and the woman would be covered.
- A young female refugee claimant was 18 weeks pregnant as a result of a sexual assault while being used as a sexual slave. She had no IFH program coverage to address the pregnancy.
- A woman in her third trimester of pregnancy develops pre-eclampsia, a potentially lethal disease, but had no coverage to treat her condition.
- A pregnant claimant is unable to get prenatal screening because she was waiting for the initiation of IFH program coverage. The baby would be a Canadian citizen.

Similar to the cases discussed above, our initial HEIA indicated that children who are in dangerous or vulnerable positions would face additional barriers to physical and emotional safety. Having limited or no access to prenatal care and early childhood interventions is likely to result in long-term development and health challenges for the children of refugees.

- A child with a high fever had no health insurance because his IFH program coverage had not been activated.
- A child could not get a chest x-ray due to a delay in the implementation of the IFH program, even though she was qualified for coverage. She eventually was found to have pneumonia.
- A child with cough, fever and vomiting was only able to access care at a free clinic due to confusion around IFH program coverage.

Changing The Interim Federal Health Program To Protect And Promote Good Health

In our initial analysis, we found that the inequitable impacts of the changes to the IFH program could not be mitigated. We showed that reducing access to critical health services would inevitably have an adverse impact on the health of already vulnerable people. Our recommendation was that the changes should not be enacted.

Unfortunately, the negative and inequitable health impacts that we predicted have occurred. The changes to the IFH program should be immediately reversed and the previous IFH program should be reinstated.

Equity Indicators And Objectives To Determine The Impact Of Changes To The Interim Federal Health Program

When implementing policy initiatives, it is important to measure impact to ensure that the policy objectives are being met and to ensure that any positive unintended consequences are enhanced and negative unintended consequences are mitigated.

In making substantive changes to the IFH program, the federal government should set out specific measurable indicators that can help to analyze whether the changes have negative health implications. Analysis of this data would help to inform future amendments to the policy to not only reduce negative health effects that may arise from the policy changes, but also to create opportunities for better health for refugees. However, it appears that the federal government is not collecting data on the impacts of their changes to the IFH program.

The impact monitoring being undertaken by Canadian Doctors for Refugee Care, however, provides a useful starting point for a more formal measurement and evaluation program. The evidence collected to date clearly shows the negative and inequitable health impacts from changes to the IFH program. This should oblige the federal government and provincial and territorial governments to undertake their own tracking.

Action Required: Federal Government

At the federal level, the government should respond to the cases that have been reported by Canadian Doctors for Refugee Care and convene a roundtable to identify opportunities to collect data more systematically.

The federal government must also ensure that it acts to eliminate negative health outcomes that have arisen from the data findings. Efforts should also be made to collect data about the extent to which refugees and claimants themselves are paying out of pocket for medical expenses and what this means for their family financial situations.

Action Required: Provincial And Territorial Governments

Provinces and territories are paying the financial price of the changes to the IFH program through increases in preventable emergency room visits and other treatment. These costs should be carefully tracked. Local and regional health authorities can lead this work by requiring or assisting health care institutions and providers to collect this data.

Provinces and territories should commit, as Quebec and Manitoba have done, to ensuring that refugees and claimants who are not longer supported by IFH program are not denied care. Refugees who are not eligible for IFH coverage should be eligible for provincial health care programs, such as OHIP. Quebec has estimated that providing health care to refugees and claimants who are no longer eligible for IFH will cost the province approximately \$3 million per annum. These costs should be tracked and regularly reported to the federal government. Manitoba has indicated that it will send the bill for providing care to refugees and claimants to the federal Minister of Health.

¹² Robert Dutrisac, "Demandeurs d'asile - Le Québec se veut plus humain, dit De Courcy", *Le Devoir*, February 12, 2013. Accessed via http://www.cocqsida.com/assets/files/Demandeurs%20asile%20Le%20Qc%20se%20veut%20plus%20humain_ledevoir_12fev2013.pdf.

¹³ Winnipeg Free Press, "Manitoba to cover refugee health benefits, send Ottawa the bill", http://www.ipolitics.ca/2012/09/13/manitoba-to-cover-refugee-health-benefits-send-ottawa-the-bill/.

Provinces and territories should build on existing resources to ensure primary and other care is available for all refugees and refugee claimants. For example, a number of specialized clinics have emerged in various cities. These clinics are a testimony to the innovation and commitment of front-line healthcare providers and should be funded by the provinces.

Another option, currently being implemented in Ontario, is to pool funds for community health centres to provide care for any uninsured patients who do not have access to the IFH program or provincial/territorial coverage. Specialized Family Health Teams could also be funded to provide services to refugees. It is important for provinces and territories to ensure that they include refugees and service providers in their discussions about ensuring that refugees have access to essential health care services.

Provinces and territories are uniquely placed to measure and report on the negative health outcomes that refugees and refugee claimants are experiencing. Some initial areas to measure include:

- Access to health care among refugees and refugee claimants, measured by ability to see a family doctor or nurse when required;
- Prevalence of chronic conditions such as diabetes or mental health issues (especially issues that refugees and refugee claimants are at particular risk of developing, like post-traumatic stress disorder); and
- The proportion of refugees and refugee claimants who are unable to fill a prescription that is required to manage a medical condition.

There are also opportunities for provinces and territories to share data in order to determine whether refugees and claimants are able to access care and, if so, the quality of the care that they receive. Provinces and territories could also make public the costs to their health systems of filling gaps left by IFH changes. These data would support efforts to demonstrate to the federal government the need to reinstate the previous IFH program.

The cuts to the IFH program also provide an opportunity for provinces and territories to review how existing policies could negatively impact immigrant and refugee health. Some provinces, including Ontario, have a mandatory three month wait period for public health care coverage for newcomers to Ontario and returning Canadians. There could be a risk of not acting on an inequitable restriction within their control, while advocating with the federal government around restrictions for refugees and refugee claimants.

Action Required: Regional Health Authorities And Health Care Providers

Regional health authorities and health care providers also need policies to ensure that refugees and refugee claimants are not denied care. Regional health authorities should endorse the documentation of impacts and adapt the Refugee HOMES tool and enable or require health care providers to document cases and track additional costs incurred in serving refugee patients. Health care providers should continue to develop contingency plans, monitor the demand and use of services by refugees, and document the impact of the cuts on individual patients and on provider costs and services. Regional health authorities should implement Access Without Fear policies, where services are provided to immigrants regardless of their immigration status. The City of Toronto recently implemented an Access Without Fear policy in the provision of city services that could be replicated and adapted by regional health authorities. 14

¹⁴ City of Toronto, Undocumented Workers in Toronto, http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2013.CD18.5.

Involving Refugees In Planning And Designing Policies That Affect Their Health

An important element of HEIA is to assess whether those groups most potentially affected have been involved in planning the proposed program or policy changes. In this case, it is important to include refugees and refugee claimants in any decisions that may have a negative impact on their health. However, the temporary nature of refugee status, in addition to language and cultural barriers, may mean that it is difficult to consult with this population directly. We therefore encouraged the federal government to utilize groups and service providers that work with refugees to connect with people who will be affected. The input of advocacy groups and support networks should be invited. It is also critical for medical professionals to provide expert advice.

It is important to note that the federal government has thus far shown little interest in including refugees and health care service providers in their decision-making. The Canadian Medical Association Journal reports that Minister Kenney failed to respond to concerns raised by eight national professional medical associations, including the Canadian Medical Association, the Canadian Nurses Association, and the College of Family Physicians of Canada. More encouragingly, Dr. Danielle Grondin, Director General of the Citizenship and Immigration Canada Health Branch, participated in a discussion of the changes to the IFH program with health care professionals and refugee health advocates in the Fall of 2012. This forum gave health care providers an opportunity to share with Dr. Grondin the barriers that refugees and claimants are facing in receiving health care services. Forums of this nature should continue on a regular basis to ensure that IFH policies can be adjusted to respond to unintended consequences of the cuts.

Conclusions

Changes To The Interim Federal Health Program Have Inequitable Health Implications For Refugees And Claimants

The changes to the IFH program have led to significant adverse impacts for refugees, as documented by Canadian Doctors for Refugee Care. There are multiple factors that have led to these adverse health outcomes, including:

- Refugees and claimants foregoing medical treatment even in emergencies;
- A lack of access to primary and preventative care contributing to the deterioration of conditions, which may become urgent;
- Refugees and claimants incurring significant medical bills that they are unable to pay;
- Female refugees and claimants being unable to access essential health care services, including in cases of sexual assault and domestic violence. There have also been cases of pregnant refugees and claimants being unable to access essential prenatal care;
- · Children of refugees and claimants being unable to access essential health care services; and
- Refugees and claimants who are eligible for IFH coverage being denied care due to administrative errors and poor communication of policy changes.

¹⁵ Canadian Medical Association, "Health care organizations wait to talk to citizenship minister about cuts to refugee benefits", *Canadian Medical Association Journal*, March 5, 2013. http://www.cmaj.ca/content/early/2013/03/11/cmaj.109-4432.

Women's College Hospital, *Women's College Hospital advocates for refugee health services*, October 1, 2012. http://www.womenscollege-hospital-advocates-for-refugee-health-services.

These negative and inequitable health outcomes are avoidable. In our initial analysis we recommended that the federal government should not pursue the changes to the IFH program. Now that the changes to the IFH program have been implemented and the negative results are evident, we again strongly recommend that the federal government reinstate the full IFH program.

It is important that provincial and territorial governments across Canada act immediately to prevent further poor health for refugees. So far, only Quebec and Manitoba have stated they will fill the gap left by the cuts to the IFH program. Other provinces, including Ontario, have voiced concern to the federal government. Ontario has not yet committed to replace IFH coverage to refugee and claimants that are no longer eligible, but they have increased funding for Community Health Centres to treat uninsured patients. This is a good start, but provinces must step up to ensure that all refugees or claimants receive appropriate care by expanding access to provincial health programs.

The evidence is clear: cuts to the IFH program are contributing to poor health for refugees and refugee claimants. We recommend that, until the federal government reverses these cuts, governments extend provincial/territorial health coverage (such as OHIP) to refugees who are not eligible for IFH coverage. Provinces and territories should also track the health outcomes of refugees and continue to advocate for the federal government to reverse its cuts.

Summary Of Actions Required

A series of immediate actions are required to mitigate and eliminate the negative and inequitable health outcomes that refugees are experiencing in Canada.

Federal Government

- 1. Reverse the cuts to the IFH program;
- 2. Respond to the cases that have been reported by Canadian Doctors for Refugee Care and convene a roundtable to identify opportunities to collect data more systematically; and
- 3. Respond to the concerns about cuts to the IFH program raised by numerous professional health care associations.

Provincial And Territorial Governments

- 1. Formally commit, as Quebec and Manitoba have done, to ensuring that refugees no longer supported by Interim Federal Health program are not denied care;
- 2. Measure and report on the negative health outcomes caused by cuts to the Interim Federal Health program;
- 3. Track the financial costs of the changes to the Interim Federal Health program through increases in preventable emergency room visits; and
- 4. Review their existing policies on eligibility for provincial/territorial health coverage to ensure that they do not negatively impact immigrant and refugee health.

Regional Health Authorities

- 1. Explicitly state that refugees and refugee claimants must not be denied care and clearly communicate this requirement to health care providers;
- 2. Endorse the documentation of impacts and adapt the Refugee HOMES documentation tool; and
- 3. Enable or require health care providers to document cases and track additional costs incurred in serving refugee patients.

Health Care Providers

- 1. Explicitly state that refugees and refugee claimants will not be denied care and develop internal protocols for staff to follow;
- 2. Endorse the documentation of impacts and adapt the Refugee HOMES documentation tool; and
- 3. Develop contingency plans and monitor the demand for services by refugees and claimants.

Appendix I: IFH Coverage Categories And Eligibility By Refugee Status

Citizenship and Immigration Canada has designated five categories of health care coverage:17

- 1. Health-Care Coverage includes coverage for most services received from a doctor or nurse in a hospital or a private clinic that Canadian citizens are covered for under their provincial or territorial health insurance plans. This includes things like seeing a doctor when you feel sick, prenatal care, and visits to a doctor to be monitored for a health condition like heart disease or diabetes. The following services and products are covered, if provided in Canada:
 - hospital services, services of a doctor or registered nurse who is licensed in Canada, laboratory, diagnostic and ambulance services, with some limitations.
 - medications and vaccines only when needed to prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern, such has HIV or tuberculosis (TB).
 - Health-Care Coverage does not cover other medications, dental care, walkers, hearing aids, home care, elective surgery or rehabilitation.
- 2. Expanded Health-Care Coverage includes coverage of the following services and products provided in Canada:
 - hospital services,
 - services of physicians, registered nurses and other health-care professionals licensed in Canada,
 - laboratory, diagnostic and ambulance services,
 - supplemental services 18,
 - supplemental products 19, and
 - translation services for health purposes.
- 3. Public Health or Public Safety Health-Care Coverage includes coverage for the following services and products, if provided in Canada, but only if they are required to diagnose, prevent or treat a disease posing a risk to public health or to diagnose or treat a condition of public safety concern (such as HIV or TB):
 - hospital services, services of a doctor or registered nurse licensed in Canada, laboratory and diagnostic services, and medication and vaccines. This coverage is very limited.
- 4. Coverage for Detainees provides coverage for services and products where a medical professional finds those products or services are required and they are urgent and essential. This includes medication and other products.
- 5. Immigration Medical Examinations means a medical examination requested under paragraph 16(2) (b) of the Immigration and Refugee Protection Act. This examination is part of the process of applying to come to, or remain in, Canada.

¹⁷ The coverage category information in this section is unedited text from http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp.

^{18 &}quot;Supplemental services" includes audiology care, emergency dental care, home care, long-term care, services provided by a midwife, occupational therapy, physiotherapy, post-arrival health assessments, psychotherapy by a registered clinical psychologist, speech-language therapy, and vision care, to the extent that they are covered in the benefit grid.

^{19 &}quot;Supplemental products" includes immunizations, medications, and medical supplies to the extent that they are covered in the benefit grid.

IFHP Group ¹	Coverage
Protected persons (other than resettled refugees)	Health Care Coverage
This group includes people who receive a	
positive decision on their refugee claim from the	
Immigration and Refugee Board (IRB) and most	
people who receive a positive decision on their	
pre-removal risk assessment (PRRA).	
Victims of Trafficking and Persons who have been	Expanded Health Care Coverage and Immigration
issued a temporary resident permit (TRP).	Medical Exams.
Persons for whom the Minister exercises	Expanded Health Care Coverage and Immigration
discretion on his own initiative for humanitarian	Medical Exams done in Canada
and compassionate considerations or for public	
policy considerations, who receive governmental	
resettlement assistance in the form of income	
support.	
Resettled refugees who are or were receiving	Expanded Health Care Coverage
governmental resettlement assistance in the form	
of income support.	
This group consists of:	
government-assisted refugees;	
other refugees who are receiving governmental	
resettlement assistance in the form of income	
support, including Visa-Office Referred refugees	
and refugees coming to Canada through the Joint	
Assistance Sponsorship Program.	
Resettled refugees while under sponsorship	Health Care Coverage
who do not receive, and have not received,	
governmental resettlement assistance in the form	
of income support.	
Refugee claimants who are not from a Designated	Health-Care Coverage and Immigration Medical
Country of Origin (DCO) (this includes those	Exams.
where there is a judicial review or appeal of	
the IRB decision pending)	
Refugee claimants who are from a DCO	Public Health or Public Safety Health-Care
	Coverage and Immigration Medical Exams.
People whose refugee claim has been suspended	Public Health or Public Safety Health-Care
	Coverage and Immigration Medical Exams.
Rejected refugee claimants	Public Health or Public Safety Health-Care
This group includes people whose claim:	Coverage
is rejected and the decision is not appealed	
is rejected and a leave application for judicial	
review is denied, or the judicial review of a	
rejected claim is denied, or any further appeal is	
denied.	
Persons who are detained under the Immigration	Coverage for Detainees & Immigration Medical
and Refugee Protection Act (IRPA).	Examinations

(Footnotes)

Table adapted from Citizenship and Immigration Canada, Information Sheet for Interim Federal Health Program Beneficiaries, http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp.

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Appendix II: Wellesley Health Equity Lens

For Policy Makers

To help policy makers quickly and effectively identify how planned policy changes or program initiatives could affect health and health inequities.

Step 1) Initial scoping: Could the policy or initiative affect health?	If yes, drilling down	Step 2) Analyze the potential impact on overall health and on the opportunities for good health of particular populations or communities.	And analyzing in detail	Step 3) Analyze how the policy or program could be changed to have a positive impact on health and health equity.
1.1 Could the planned policy, budget decision, program or initiative impact overall health, either by affecting employment, income, housing or other determinants of health, or by affecting access to health, social and other services and support?		2.1 How will the planned policy change or initiative affect overall health or the identified community? For example: could adding user fees for recreation activities prevent some people from accessing them? Could reducing funding for child care spaces cause children to be placed in unsafe settings or parents to withdraw from paid work to care for their children?	\Rightarrow	3.1 How can you maximize the positive health and equity impacts of the planned policy change or initiative? For example, could community development or health promotion programs be concentrated in the most socially and health disadvantaged communities that need services the most?
1.2 Could the planned policy,		2.2 Could the planned policy		3.2 How can you mitigate or
budget decision, program or		change or initiative worsen		eliminate the inequitable impacts
initiative have an inequitable		health inequities between		of the planned policy change or
impact on particular groups or		different groups or communities?		initiative?
communities? If so, which people		Health inequities are differences		For example, by designing any
or communities?		in health outcomes that		funding and program reductions so
Examples of people and		are avoidable, unfair, and		they do not have a disproportionate
communities to consider are:		systematically related to social		effect on lower-income people
homeless or poorly housed;		inequality and disadvantage.		and communities, or by ensuring
recent immigrants; those in		1 10 1111		appropriate interpretation, adopting
precarious and low paid work,		For example, if child care		flexible or longer opening hours
people with disabilities; racialized		subsidies are cut, this will affect		to accommodate work schedules,
populations; Aboriginal people;		lower income parents the most.		providing transit subsidies or
others facing social inequality and exclusion.		If changes in industrial policy increase unemployment and		childcare so people can access services, etc.
exclusion.		precarious work, this will be		services, etc.
This basic aquity long should be		associated with poorer health for		
This basic equity lens should be				
applied to most policy decisions.		lower income people.		

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2.3 What more do you need to know to determine the potential impact of the planned policy change or initiative? For example, do you need information from service providers about program use, neighbourhood-level data, or more demographic information about the affected people or communities?	3.3 How will you know whether the policy change or initiative has had a positive health impact? What health and equity indicators will be used to measure impact?
	3.4 How can you involve the people affected or who the program serves in planning, designing and evaluating the initiative to determine service gaps and program/policy success?