

Refugee Health Care Cuts In Canada

System Level Costs, Risks and Responses

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EXECUTIVE SUMMARY



Refugee Health Care Cuts In Canada: System Level Costs, Risks and Responses

When reforms to the Interim Federal Health (IFH) program were announced, health care providers raised a number of concerns about the significant reduction in access to health care services for most refugees and claimants. This research study documents how four key fears of health care providers have been realized since the cuts took effect. First, a complicated framework of coverage produces administrative burdens for health care providers that can lead to denial of care even when refugees have valid IFH coverage. In addition, there has been increased use of emergency rooms for conditions that could have been more effectively treated through primary care and the Designated Country of Origin (DCO) list has created a class of refugee claimants who have virtually no access to health care services. Last, health care access for vulnerable refugee groups, including pregnant women, who only have coverage if they have a condition that poses a public health risk, has been reduced resulting in increased risk and complications for patients.

Strong evidence suggests that compared to other groups, refugees have poorer health due to their experience of displacement and the difficult resettlement process. The compounding effects of these experiences can lead to compromised physical and mental health. In addition, settlement barriers to employment, language barriers and other social determinants of health create a situation where health is negatively impacted.

This report's findings show that a standard approach for serving uninsured and under-insured refugee patients and efficiently managing the administrative complexities of the IFH is absent. To ensure that refugees who need to access health care don't fall through the cracks this report highlights several opportunities for action.

Introduction

On June 30, 2012, the federal government introduced major amendments to the Interim Federal Health (IFH) program.¹ The IFH is a federally administered program that was originally introduced to provide health care insurance coverage for all refugees, particularly those who are not covered by provincial or territorial health insurance programs. The original IFH program operated within a universal coverage framework and covered all categories of refugees. In contrast, the amendments create a conditional and differential model of health coverage, where the type and level of IFH coverage depends on the refugee category.

The amendment to the IFH program is in line with broader immigration policy reforms passed under Bill C-31. Among other things, Bill C-31 gave the Immigration Minister the power to create a Designated Country of Origin (DCO) list of countries considered to be “safe,” and limited the rights of refugee claimants from these countries. This led to the creation of varied categories of refugees, with differential refugee claim processing and access benefits. With changes to the IFH program, it eliminated health coverage (except in cases of public health or public safety risk) to refugee claimants from DCOs² and rejected refugee claimants that have exhausted the appeal and judicial review process. The DCO provisions came into effect on December 15, 2012. Evidence from the federal government to support reasons for this policy direction has however not been made public to date.

List of DCO countries: Australia, Austria, Belgium, Chile, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel (excludes Gaza and the West Bank), Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, South Korea, Spain, Sweden, Switzerland, United Kingdom, and United States of America

As stated in the official policy document put forth by the federal Minister of Citizenship and Immigration, the key goals of the IFH amendments were:³

- Ensure the IFH program coverage is limited to urgent or essential health care services;
- Continue to provide health services (e.g. hospital and physician services) under the “Health Care Coverage” package to refugee claimants and privately sponsored refugees;
- End coverage of supplemental benefits (e.g. pharmaceutical, dental, or vision services), but will provide for immunization and medication needed to protect public health or public safety;
- End all IFH program coverage to rejected refugee claimants, other than services and products that protect public health or public safety;
- Limit coverage to refugee claimants from DCOs by providing only services and products that protect public health or public safety;
- End all IFH program coverage for Pre-Removal Risk Assessment applicants who have not applied for refugee status during their current stay, providing benefits only once protected person status is conferred; and

1 Government of Canada, Department of Justice. Order Amending the Order Respecting the Interim Federal Health Program (SI/2012-49). Canada Gazette, June 28, 2012, <http://canadagazette.gc.ca/rp-pr/p2/2012/2012-07-18/html/si-tr49-eng.html>.

2 This applies to refugee claimants that submitted a claim after December 15, 2012.

3 Order Respecting the Interim Federal Health Program, 2012, <http://www.gazette.gc.ca/rp-pr/p2/2012/2012-04-25/html/si-tr26-eng.html>.

- Retain ministerial discretion to provide IFH program coverage in exceptional and compelling circumstances, including to individuals admitted under public policies.

Health care providers across Canada opposed the policy changes on the grounds that refugees with Public Health or Public Safety Health Care Coverage would receive less care and care only when conditions that could have been prevented reach a critical condition. This report documents health care system implications from the IFH program changes, potential consequences on health care access to vulnerable refugee groups focusing on those belonging to the DCO list and rejected claimants⁴, and how health care and other service providers developed local innovative service solutions to mitigate the negative health consequences on refugee clients. The observations discussed in this report are based on in-depth interviews with 18 key study participants from different disciplines related to refugee and newcomer health care, public policy and clinical services from across Canada. In addition, a review of secondary literature on implications of IFH cuts, including peer reviewed academic publications, reports on public health programs, immigration, and social care, and media articles are used.

Study results show that IFH reforms:

- Create a complicated framework of coverage that produces unnecessary administrative burdens to the health care system;
- Create unequal access to health care for different refugee groups;
- Reduce health care access for vulnerable refugee groups (including to pregnant women) with IFH Public Safety Health Care Coverage, and thereby puts them more at risk and complications;
- Increase use of emergency rooms for non-emergency conditions.

In addition, this report found there was little or no consultation from the federal government with health care providers about the need or impacts of these reforms. These findings build on the Health Equity Impact Assessment (HEIA) report on the IFH cuts published by the Wellesley Institute in May, 2012 and updated in October, 2013.⁵ The negative health outcomes, including women being unable to access prenatal care, health conditions that have worsened due to lack of access to timely preventative and/or early intervention care and refugees being unable to access prescription drugs. These negative impacts could only be prevented by not pursuing the IFH policy change. Given the government's decision to pursue the policy they should have delayed the implementation until they could appropriately study and address the anticipated negative health impacts. Findings from this report indicate that it was the federal government's reforms of the IFH program that pose substantive risks to the health of refugees seeking asylum in Canada.

Background To Interim Federal Health Program

The Original Interim Federal Health Program

The program was introduced in 1957 for humanitarian reasons, with a goal that the program would

4 Rejected claimants maintain their right to IFH Health Care coverage until final rejection of their claim (i.e. until they have exhausted all appeals).

5 Barnes, S., The Real Cost of Cutting Refugee Health Benefits: A Health Equity Impact Assessment, The Wellesley Institute, 2012, <http://www.wellesleyinstitute.com/wp-content/uploads/2012/05/The-Real-Cost-of-Cutting-Refugee-Health-Benefits.pdf>.

“contribute to optimal health outcomes in a fair, equitable and cost effective manner.”⁶ The IFH program provided healthcare coverage to vulnerable groups like refugees that may not have provincial and territorial coverage and/or as supplementary coverage to vulnerable groups. The IFH program provided coverage similar to provincial and territorial coverage for people receiving social assistance and included coverage for prescription drugs, dental, vision care, emergency medical and special assistive devices. The IFH program was and continues to be administered on behalf of the federal government by Medavie Blue Cross, a private insurance company.⁷

Prior to June 30, 2012, the IFH program provided temporary medical coverage to three categories of persons: refugee claimants, protected persons, and resettled refugees. These three categories received the same level and type of coverage from IFH program. While the IFH program was highly valued by health care providers that worked with refugee communities, service providers and researchers had identified certain limitations within the original IFH program:

- There were exceptions to primary care such as ‘well baby’ visits and certain types of periodic screening, because the doctor had to conclude with a diagnosis, so there had to be symptoms.
- Administrative obstacles:
 - For clients: delays in processing their applications for the IFH certificate to confirm coverage. Refugee claimants would remain eligible for IFH until their claim was settled. This was of particular concern given the Immigration and Refugee Board (IRB) backlogs, where estimated delays varied from 14 months to 5 years or more, with immigration appeals taking an average of 11 months.⁸ Refugee claimants were therefore more significantly affected by the limitations of IFH program than Government-Assisted Refugees.⁹
 - For service providers: health care providers were reimbursed directly for services by Medavie Blue Cross. This administrative process was deemed burdensome due to special billing requirements, lack of information, cumbersome paperwork, and slow, complex reimbursement process.¹⁰
 - Several health care providers in this study echoed these observations, noting that their refugee clients were unfamiliar with the Canadian health care system, in terms of knowing the “how” to access services which resulted in system navigation concerns. Furthermore, from a quality of care perspective, many health services were not culturally competent in their practice, and therefore could be insensitive for individuals who hold non-Western values.

While these challenges were significant and changes were required, the original IFH program provided essential health care services to all refugee categories.

Changes To The Interim Federal Health Program

On June 30, 2012, the federal government’s amendments to the IHF program resulted in tiered and unequal health care coverage for refugees. The revised IFH program created three different streams of health

6 Citizenship and Immigration Canada, Interim Federal Health Program: Information handbook for health care providers, FAS Benefit Administrators Ltd, 2006.

7 Medavie Blue Cross, Citizenship and Immigration Canada, <https://provider.medavie.bluecross.ca/>.

8 Immigration and Refugee board of Canada, Departmental Performance Report 2007-2008, 2008, <http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/inst/irb/irb00-eng.asp>.

9 Wales, J., ‘Interim federal health: A public health perspective’, British Medical Ultrasound Society, 2010; 7(1).

10 Gagnon, A.J., ‘Responsiveness of the Canadian healthcare system towards newcomers’, Discussion Paper No. 40. Ottawa, ON: Commission on the Future of HealthCare in Canada, 2002, <http://dsppsd.pwgsc.gc.ca/Collection/CP32-79-40-2002E.pdf>

coverage. Each stream caters to different refugee categories and the level of coverage varies accordingly. The Expanded Health Care coverage is for government assisted refugees (GARs), Health Care coverage is for accepted refugee claimants and privately sponsored refugees, and Public Health and Safety Health Care coverage is for claimants' from the Designated Countries of Origin (DCO) list and rejected claimants'.¹¹ The result of these changes is restricted access to health care services for many refugee categories and eliminated health coverage for some claimants.

There is strong evidence from Canadian and international studies that, compared to other groups, refugees generally have poorer health due to their experience of displacement and the difficult resettlement process.^{12,13} Refugees may have experienced traumatic events such as war, family separation, physical and psychological torture; stayed in overcrowded refugee camps for extended periods; experienced acute deprivation; prolonged periods in immigration detention; and generally have poor access to health care prior to arrival.¹⁴ The compounding effects of these experiences can lead to severely compromised physical, mental, and social health.¹⁵ Furthermore, upon arrival, refugees face settlement barriers related to unemployment and language difficulties and that may limit their awareness of social services that can assist them in addressing settlement issues.^{16,17} Against this background, the coverage provided by the original IFH program played an important role in enabling health care providers to provide equitable health care. Creating a complicated and unequal health care coverage for refugees based on administrative categories is a significant departure from the original IFH model.

Public Health Or Public Safety Health Care Coverage

This report focuses on the Public Safety Health Care coverage which is available to those from the DCO list and rejected claimants. This is because this coverage stream is most restrictive in terms of access to health care services, such as medication and hospital facilities offered. Table 1 provides an overview of this coverage stream.

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- 11 For further details, see Information Sheet For Interim Federal Health Program Beneficiaries, <http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp>.
 - 12 Petevi M, *Forced Displacement: Refugee Trauma, Protection and Assistance*. In *International Responses to Traumatic Stress*, Danieli Y, Rodney N, and Weisaeth L, (Eds). United Nations Publication, Baywood Publishing Company, New York 1996.
 - 13 Petevi M, Revel J.P., Jacobs, G.A. WHO tool for the Rapid Assessment of Mental Health Needs of Refugees and Displaced Populations and Resources, in *Conflict and Post-Conflict Situations*. Pre-final draft. WHO, Geneva 1999.
 - 14 Lawrence, J., & Kearns, R., 'Exploring the 'fit' between people and providers: Refugee health needs and health care services in Mt. Roskill, Auckland, New Zealand', *Health and Social Care in the Community*, 2005; 13(5), 451-461.
 - 15 Olness, K., 'Refugee health', in Loue, S. (editor), *Handbook of immigrant health*, New York: Plenum Press; 1998. pp. 227-42.
 - 16 McKeary, M., & Newbold, K.B., 'Barriers to care: The challenges for Canadian refugees and their health care providers', *Journal of Refugee Studies*, 2010; 23(4), 523-545.
 - 17 Mulvihill, M.A., Mailoux, L. & Atkin, W., *Advancing policy and research responses to immigrant and refugee women's health in Canada*. Winnipeg: The Centres of Excellence in Women's Health; 2001.

Table 1: Overview of the Public Health or Public Safety Health Care Coverage¹⁸

Who?	What is covered?
i. Claimants from Designated Countries of Origin that submitted a claim after December 15, 2012. ii. Rejected claimants that have exhausted all appeal and judicial review process.	No health care coverage except for medical services if they are required to diagnose, prevent or treat a disease posing a risk to public health or conditions of public safety concern.

Note: “Disease posing a risk to public health” means a communicable disease that is on the list of national notifiable diseases of the Public Health Agency of Canada which is subject to human to human transmission and requires public health intervention, or for which immunization has been recommended under Canadian medical standards. The “condition of public safety concern” means a mental health condition in a person who has been examined by a physician licensed in Canada and for which the physician is of the opinion that the person will likely cause harm to others.¹⁹

Under Bill C-31, the DCO refers to claimants originating from countries generally considered to be “safe.” Citizenship and Immigration Canada has a two-step process for determining whether a country is designated as “safe”: i) a rejection rate of 75 percent or higher for refugee claims and/or an abandonment/withdrawal rate of 60 percent or higher, and ii) a review of whether the country has an independent judicial system, recognizes democratic rights and freedoms, and has civil society organizations.²⁰ Refugees from DCOs have 30-45 days to make their claim to the IRB. Failed DCO claimants may apply to the Federal Court to review a negative decision; however, they do not have access to the Refugee Appeal Division at the IRB.

The DCO list has proven controversial because it treats refugees differently based on their country of origin. The Canadian Council for Refugees argues that claimants from designated countries will face a bias against them since decision-makers will be aware of the government’s judgment. Denial of a fair process to these claimants may lead to their forced return to face persecution, in violation of human rights law.²¹ The DCO list has also been criticized for failing to recognize that not all populations are safe even within countries that are safe for most of their citizens. Key examples include the Roma population in Hungary and lesbian, gay, bisexual, and transgender populations in many countries.²² The faster processing times that has been instituted may not allow claimants’ time to properly prepare their documentation and cases. Moreover, there are also legislative changes that reduce access to appeals for refugee claimants. This coupled with the stress of limited to no health care coverage upon their arrival in Canada, can place DCO claimants in a more precarious situation.

The other refugee category included under the Public Safety Health Care coverage is rejected claimants. These refugee claims have Public Safety Health Care coverage between the moment when they exhaust all

18 For details, see Citizenship and Immigration Canada, Information Sheet For Interim Federal Health Program Beneficiaries, <http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp>, and Cleveland, J., Health care for refugee claimants: Impact of Interim Federal Health Program (IFHP) cuts, 2012, <http://oppenheimer.mcgill.ca/Health-Care-for-Refugee-Claimants>.

19 For details, see Citizenship and Immigration Canada, Interim Federal Health Program Policy; 2.1 Disease posing a risk to public health, June 30, 2012, <http://www.cic.gc.ca/english/department/laws-policy/ifhp.asp>. Also see, Medavie Blue Cross, Important Information For Service Providers, <https://www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187212378312&blobheader=application%2Fpdf>.

20 Citizenship and Immigration Canada, Backgrounder: Designated Countries of Origin, 2012, <http://www.cic.gc.ca/english/department/media/backgrounders/2012/2012-02-16i>.

21 Canadian Council for Refugees, Refugee Reform: Weighing the proposals, <http://ccrweb.ca/files/c-11weighingproposal.pdf>.

22 Alboim, N. and Cohl, K., Shaping the Future: Canada’s rapidly changing immigration policies, Maytree Foundation, October 2012.

appeal and judicial review procedures, and the date set for their deportation from Canada.

Research Methodology

Qualitative data was collected over a 7 month period, from January–July, 2013 through in-depth interviews with 18 study participants. Participants included health care providers working specifically with refugee patients were first identified, and thereafter key informants including front-line staff (e.g. social workers, lawyers), as well as those in decision making and policy position (e.g. Executive Directors of community and clinical services, NGOs, and health policy analysts) were recruited through a snowball sampling technique.²³ The study included participants from across Canada in order to assess impact on a national scale. Interviews were conducted in person, by telephone, and through Skype, depending upon the needs of participants. This research was conducted in accordance with the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, and received approval from the Research Ethics Board at McMaster University. In addition, archival data of media coverage and material on the IFH cuts, and government reports primarily from Citizenship and Immigration Canada were examined. These are complemented with peer-reviewed literature on refugee health.²⁴

Study Findings

Study findings highlight that the amendments to the IFH program are having two fundamental, adverse impacts. First, the changes to the IFH are leading to reduced and unequal access to health care for vulnerable refugee groups. Second, the amendments also impact health care professionals' ability to provide timely care to all refugees. The results are reported under five themes: administrative complexity and hurdles; reduced and unequal health care access, including risks to pregnant refugees; putting health care providers in ethical dilemmas; shifting of health care costs; and service provider responses.

Administrative Complexity And Hurdles

“The new IFH is a painful bureaucratic maze to work through! No one is still clear on what exactly our patients are covered for or not, and this is not the reason why I became a doctor.”

A significant unintended consequence of the IFH cuts is the confusion faced by service providers in navigating the revised IFH program. For health care facilities, there are now additional administrative tasks to assess and confirm a patients' eligibility for coverage. The main consequence of confusion is that many refugee claimants, those with IFH Health Care coverage are refused services or asked to pay for care which they are entitled to.

23 Miles, M. B., & Huberman, A. Michael. (1994). *Qualitative data analysis: An expanded source book*. Thousand Oaks, CA: Sage Publications.

24 Few examples include: Backman, G. et al. (2008). Health systems and the Right to Health: An Assessment of 194 Countries. *The Lancet*, 372(9655), 2047–2085; Clinton-Davis L, Fassil Y. (1992). Health and social problems of refugees. *Social Science and Medicine*, 35(4), 507-13; Gray, B.H & Ginneken, E.V. (2012). Health Care for Undocumented Migrants: European Approaches. *The Commonwealth Fund*, 33; Hull, S.A. (2006). Primary care for refugees and asylum seekers. *British Medical Journal*, 332(7533), 62–63; Leeman, L & Fontaine, P. (2008). Hypertensive disorders of pregnancy. *American Family Physician*, 78(1), 93-100; McKeary, M., & Newbold, K.B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies*, 23(4), 523-545.

Since November 2012, it is possible for health care providers to check patients' IFH coverage online on the Medavie Blue Cross site. However, study participants noted that this is a time-consuming process and not a realistic expectation in a busy health care setting. One participant, whose main task is to confirm refugee IFH eligibility with Medavie, reported that often there is a time delay of at least two business days for coverage to be activated in the Medavie Blue Cross' system after it is issued by CIC. CIC materials confirm that two business days is required to update the client information.²⁵ This means that there could be a change in coverage from IFH Health Care to Public Safety Health Care coverage (after final rejection of the refugee claim), but neither the patient nor their health care provider is aware of the change.

Guidelines on the diseases and conditions covered under the Public Safety Health Care coverage are listed in the Medavie Blue Cross — IFHP Benefit Grid.²⁶ If the patient is diagnosed with one of the 35 contagious disease listed in the grid or with a psychotic disorder representing a threat to others, the claim is covered by IFH. In addition, IFH will pay for the initial clinic/hospital visits, diagnostic investigations (e.g. imaging and laboratory) required to rule out a disease posing a risk to public health or a condition of public safety concern. The problem is that doctors and service providers may not be familiar with the Medavie Blue Cross criteria, and they are complex and thus, hard to apply.²⁷

Unable or unwilling to deal with the revised IFH complexity, there is evidence that some health care providers now ask refugee patients to pay up front for their visits, regardless of whether they are eligible for IFH coverage or the type of coverage they have. A recent study on the refugee health care cuts reported that in Ottawa, only 9 out of 33 walk-in clinics were accepting refugees as patients. In cases where refugees were seen, they were charged fees of up to \$60.90.²⁸ Refugees' fear of the cost of health care (actual and perceived costs) has led to a trend of delayed health seeking behaviour, which may lead to poorer health outcomes. This can result in ineffective management of acute and chronic illnesses and long-term disabilities and morbidity.

Legally trained participants who work closely with refugee cases noted that another pertinent factor contributing to the IFH administrative complexity is the case of failed refugee claimants from moratorium countries: Afghanistan, the Democratic Republic of Congo, Haiti, Iraq and Zimbabwe. Despite refugee applicants from these countries being rejected, they cannot be returned to their country of origin due to the principle of non-refoulement, an international principle which makes it illegal to return a refugee to a country where their lives or freedoms could be threatened. Such rejected claimants residing in Canada are in a state of legal limbo which can continue for years.

Examples of refugees in legal limbo in Canada and their health needs:

- A failed refugee claimant from Iraq, a country that has been declared too dangerous to deport claimants to since 2003, has Wilson's disease, a genetic disorder that puts one at risk of life-threatening organ damage. Since the IFH cuts, the claimant no longer get monthly blood and urine tests, and liver

25 Citizenship and Immigration Canada, Information Sheet For Interim Federal Health Program Beneficiaries.

26 Medavie Blue Cross, IFHP Benefit Grid - Public Health and Public Safety, note 22 and 23, in combination for the list of conditions and diseases listed in Appendix A <https://www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobheadername2=MDT+Type&blobkey=id&blobwhere=1187212811067&blobheader=application%2Fpdf>

27 Based on feedback by service providers and practitioners familiar with the IFHP Benefit Grid

28 Eggertson, L., 'Doctors promise protests along with court challenge to refugee health cuts', Canadian Medical Association Journal, 2013;185(7).

ultrasounds to monitor this condition.

- A failed refugee claimant from Afghanistan who is a Type 1 diabetic, is being kept alive on free samples of insulin from a community medical clinic in Ottawa.²⁹

Reduced Health Care Access And Implications

“I feel like I’m practicing third world medicine in Canada!”

Several health care providers noted that with introduction of the new IFH program, refugees and providers are facing increased confusion about IFH eligibility. These difficulties are aggravated by the unease and anxiety related to uncertainty around what each claimant is entitled to, and can result in eligible refugees being discouraged from using public health services. The implications of this are that many cannot obtain primary health care or treatment for chronic diseases and do not have access to health promotion programs.

In terms of reduced access to preventative care, not all infectious diseases, such as a typical community acquired pneumonia, are covered under the Public Safety Health Care Coverage.³⁰ Study participants noted that an indirect consequence of not being able to perform comprehensive medical assessments of their refugee patient’s health and illness could put the general public at risk from unknowingly contracting a variety of diseases. Some infectious diseases which are uncommon in developed countries, but endemic in developing countries can pose considerable health risks to refugees in Canada due to the absence of timely diagnosis, regular monitoring and treatment.

Health care provider participants highlighted that refugees tend to come from countries with minimal health care resources and limited immunization, and for that reason providing them with primary care is critical to maintaining the health of refugees and the general public in the resettlement country. Thus, poor primary care and interrupted continuity of care may mean that illnesses could be missed and result in potential public health risks.

Risks To Pregnant Refugees

The revised IFH program places pregnant refugees at disproportionate health risks. Study participants from midwifery centres and community health centres (CHCs) indicated that since the IFH cuts took effect, obstetricians have been turning away pregnant claimants irrespective of their immigration status, and even if they had Expanded Health Care Coverage. This refusal of care is linked with fears that the pregnant women’s legal status may change within the time of the pregnancy. When an obstetrician takes on a patient, it is normally a substantial commitment through the term of the pregnancy to the post-partum period. Some obstetricians are reluctant to provide care to refugee patients if it is not certain that they will be reimbursed for the entire duration of care.

Study participants have been documenting cases where hospital administrative staff require pregnant refugees, even those with valid IFH documentation for Expanded Health Care Coverage, to sign waivers stating that they are responsible for paying all medical service fees in case their IFH coverage changes. As

29 Hasham, A, Refugee health cuts: Doctors launch Charter challenge in federal court, The Toronto Star, February 25, 2013, <http://www.thestar.com/news/canada/2013/02/25/>

30 Sheikh, H., ‘Refugee health: Providing the best possible care in the face of crippling cuts’, Canadian Family Physician. 2013;59(6), 605-606.

one key participant noted, “for refugee women in impoverished positions this is a daunting experience.” As a result, pregnant refugees may delay seeking pre/post natal care. Participants reported that some obstetricians have withdrawn services, “leaving their patients half-way” or stopping care during pregnancy due to the financial uncertainties resulting from the IFH reforms. The interruption of care is serious for all pregnant women but could have serious and disproportionate consequences for those who have chronic conditions, such as diabetes, hepatitis or high blood pressure, which require regular monitoring and medication.

High risk pregnancies are of particular concern as the absence of appropriate regular care can result in serious complications for the mother and child, such as premature birth or low birth weight. Research evidence suggests that uninsured women are more likely to have untreated diabetes and hypertension, which can affect the child’s development, resulting in maternal, fetal, and neonatal morbidity and mortality.³¹ The children born of these women are Canadian citizens by birth and any adverse health consequences caused by a lack of prenatal care will be provided under provincial or territorial health coverage. It is therefore counterintuitive to deny fair access to prenatal and postnatal care. Through key informant interviews with one midwife, two case illustrations were discussed which provide some insight into the serious complications for women seeking prenatal care under these circumstances.

Case 1: A woman with valid IFH coverage in the process of having her refugee claim processed was receiving routine prenatal care from an obstetrician. A few weeks after the IFH program amendments were introduced, the woman presented for a regular visit to her obstetrician. She was at term in her pregnancy and had been seeing the obstetrician for all of her care until that time without any issues. At this appointment, she was informed that in order to return she would need to bring \$1500 to pay the obstetrician or else she would not be able to return. At term in pregnancy, women are seen weekly, which meant the woman would need to come up with these funds within one week. The woman knew that she would not be able to secure this amount within such a short time frame. She presented to a midwifery practice in her area, quite distressed and pleading to take her into care. The midwifery clinic was full at the time, but agreed to take on the woman’s remaining care understanding that she was quite far along in pregnancy and unable to find another care provider.

The midwifery clinic’s office administrator checked the woman’s IFH Program status and confirmed that the woman did in fact have regular IFH coverage. Prior to June 30, 2012, all refugee claimants and resettled refugees had access to what is now equivalent to the “Expanded Health Care Coverage.” The administrator called the obstetrician’s office and informed them about the pregnant patient having valid IFH coverage. Despite this information, the obstetrician’s office stated that because refugee status was now subject to change at any time, they were not willing to keep the patient in care without a down payment. They were unwilling to take the financial risk of not being reimbursed for her

31 Leeman, L & Fontaine, P., ‘Hypertensive disorders of pregnancy’. *American Family Physician*, 2008;78(1), 93-100.

treatment, regardless of the fact that the pregnant woman had valid IFH documentation.

Case 2: A pregnant claimant of Mexican origin was in the final weeks of her pregnancy. She went to pre-register herself at the hospital, which is the routine practice for all pregnant patients. The hospital administrator informed her that she would have to pay the uninsured fee of \$2600 for her stay in the hospital during birth. This was shortly after December 2012 when Mexico was added to the DCO list. However, the woman's IFH coverage was unaffected because it was valid before the policy changes. Her midwife subsequently advocated for her at the hospital and after review of the IFH-DCO policy the hospital stated it would not require her to pay the \$2600 fee. However, she was required to sign a document stating that if her IFH coverage changed she would pay the amount in full. This was a new policy established as a result of the IFH changes and because of concerns at the hospital about reimbursement for refugee claimants. As a result of these financial concerns, the client chose to have a midwife attended homebirth. While homebirths with midwives in Canada has been demonstrated in research to be a safe alternative to hospital delivery, this woman was not choosing homebirth because she felt it was the best option for her, but rather because she was concerned about the financial implications of a hospital birth. In fact, this woman reported that she felt quite unsafe having the baby at home, but could not come up with the funds required by the hospital if that was required of her.

Despite the fact that the midwife did clarify the woman's valid IFH coverage at the hospital, the hospital had institutionalized a policy that required women with IFH coverage to sign a waiver ensuring that if their IFH program status changed, they would accept liability for an administrative fee of \$2600 per day to cover costs associated with a hospital delivery.³²

Putting Health Care Providers In Ethical Dilemmas

“As a Canadian physician, I feel a certain amount of personal shame that my country is creating so much problem for refugee patients here...it's very sad and intensely frustrating for us.”

The administrative complexities of the revised IFH program has resulted in many walk-in-clinics turning away refugee clients, despite them having valid IFH documentation.³³ One interviewee stated that “patients are being orphaned by their physicians” noting that many providers have been unwilling to clarify changes to the IFH program and Medavie Blue Cross guidelines for eligibility. This growing reluctance can be linked with several issues in the operationalization of the new IFH program: complexity of the IFH regulations,

³² Source: Key informant interview with a midwife who works closely with refugee clients.

³³ A finding from the Refugee HOMES tracking tool that Canadian Doctors for Refugee Care established for health care providers to report adverse outcomes for refugee patients. The tracking tool and background information is available at: <http://www.doctorsforrefugeecare.ca/furtherreading-survey.html>.

increased administrative time required per refugee patient to confirm their coverage stream, and if the patient lacks sufficient funds, whether the health care facility is willing and/or able to absorb the costs and whether the facility will be reimbursed by the government.

A moral dilemma arises for health care providers when patients lack coverage for the health care they require. Several health care providers who participated in the study commented that the IFH Public Safety Health Care coverage's definition of public health and safety is too narrow and is inconsistent with their professional work and medical training, as public health encompasses preventive primary care and not only treatment for specific diseases.

Shifting Of Health Care Costs

“The number of uninsured refugees in Canada is not known, and the ones that do manage to receive some medical care at a hospital or clinic are the lucky ones!”

The federal government is expected to save \$20 million annually by 2017 as a result of the IFH amendments.^{34,35} This will be achieved through fast removal of unfounded refugee claimants and by reducing health care coverage for certain groups of refugees. According to the federal government, the IFH amendments will allow the government “to protect public health and safety, ensure that tax dollars are spent wisely and defend the integrity of [the] immigration system all at the same time.”³⁶ No evidence was presented to support these arguments or claims.

Study participants highlighted that since the amendments to the IFH were introduced, there have been costs due to untreated illnesses that were not factored into the federal government's projected cost-savings. Under the Public Safety Health Care coverage, refugees with chronic health conditions such as heart disease, diabetes, or asthma, may be forced to forgo preventive health care due to the financial costs of care, and have to rely on the use of more expensive emergency services, since these diseases are not covered under this coverage. In Ontario, which has 55 % of all refugee claimants in Canada, hospitals in the Greater Toronto Area expected to absorb costs generated by the IFH cutbacks. According to the University Health Network, which includes Toronto General, Toronto Western and Princess Margaret hospitals, and Toronto Rehab Institute, estimated a bill of \$800,000 for services delivered to the uninsured in its emergency department alone.³⁷ These figures raise two important issues. First, the shift in costs from the federal government to provinces, for refugees with the Public Safety Health Care coverage; and second, the risk of increased costs (that are also shifted to the provinces) because of delayed care.

One interviewee noted that another critical but overlooked aspect of the IFH cuts is that some refugees

34 Saskatoon doctors, former refugees protest health cuts, CBC News, June 18, 2012, <http://www.cbc.ca/news/canada/saskatchewan/saskatoondoc-tors-former-refugees-protest-health-cuts-1.1178337>.

35 Canadian Healthcare Association, Changes to the Interim Federal Health Program: Position Statement, Canadian Healthcare Association, November 2012, <http://www.cha.ca/wp-content/uploads/2012/11/IFHP-reform-policy-statement-November-2012.pdf>

36 Citizenship and Immigration Canada, News Release – Reform of the Interim Federal Health Program ensures fairness, protects public health and safety, <http://www.cic.gc.ca/english/department/media/releases/2012/2012-04-25.asp>.

37 Keung, N., 'Ontario hospitals absorb health costs to treat refugees', Toronto Star, June 8, 2013, http://www.thestar.com/news/immigration/2013/06/08/ontario_hospitals_absorb_health_costs_to_treat_refugees.html; Reinstating Access to Health Care for Refugee Claimants, Ontario Filling Federal Funding Gap with Temporary Health Program, December 9, 2013 <http://news.ontario.ca/mohlhc/en/2013/12/reinstating-access-to-health-care-for-refugee-claimants.html>

will eventually become Canadians (permanent residents or citizens). These new Canadians will face greater health risks because timely access to primary and preventive health care may have been limited or restricted while their application was being processed. Provincial and territorial Health Ministers recently reported that “hospitals and other health care providers have assumed costs that had previously been borne by the federal government.”³⁸

Service Provider Responses

In response to the restricted health care access faced by certain refugee categories, existing safety-net clinics and hospitals offering free or reduced-priced medical care have attempted to address the increased demand. In addition, new clinics catering specifically to uninsured or underinsured refugees are being setup.

To tackle the IFH program administrative complexities, health care providers and frontline staff are coming up with innovative practices, such as creating partnerships between different clinics, to make efficient use of limited resources and for referrals for the increasing number of uninsured persons. For example, many obstetricians are no longer accepting pregnant refugees without a CHC referral – this has led to many CHCs taking on extra administrative tasks. Another example is Refuge Hamilton Centre, which is run primarily through pro bono work by local doctors and nurse practitioners. They have also recently partnered with McMaster University’s School of Nursing, which will enable third-year student nurses to do placements there.³⁹ Such partnerships and practices reflect the development of local innovative solutions to meet refugee health needs and they lay the groundwork for sustainable forms of collaboration. In addition, service providers are organizing public information meetings to generate awareness on the refugee health cuts and impacts. For example, Canadian Doctors for Refugee Care organized a National Day of Action on 17 June, 2013 in several cities to bring public awareness of the cuts, and this included demonstrations in front of legislatures and city halls.

To address public health risks, study participants highlighted that some clinics have been documenting refugee patient outcomes where they were asked for upfront payment at health facilities or denied health care. Some hospitals are also recording the number of refugee patients without the IFH Expanded Health Care coverage using emergency department services. The information gathered will generate an evidence base that can be used to identify health issues and system level problems at the local level. But more systematic and consistent information gathering is required in order to differentiate between different impacts such as risk of communicable diseases, limited resources being diverted, and emergency room bottlenecks.

Study participants recommended increasing preventive health care services for refugee clients within the Public Safety Health Care coverage, especially given the known health benefits and cost effectiveness of such health promotion interventions. This has potential to reduce the burden and risk of disease and

38 Ontario Ministry of Health and Long-Term Care, Provincial and Territorial Health and Wellness Ministers Focus on Quality and Prevention for Patients and Their Families, October 3, 2013, <http://news.ontario.ca/mohlct/en/2013/10/provincial-and-territorial-health-and-wellness-ministers-focus-on-quality-and-prevention-for-patient.html>.

39 CBC News, New clinic for refugees opens in Hamilton, <http://www.cbc.ca/news/canada/hamilton/news/new-clinic-for-refugees-opens-in-hamilton-1.1381820>.

assure greater health equity, by preventing refugees from being forced to use emergency department resources. These findings indicate the IFH program should include primary health care as a high priority in Canada's health strategy for newcomers.

Despite all these substantive efforts, the new IFH program and its complexities are a disincentive to health care providers to treat refugees. Moreover increased demands on providers due to the IFH cuts may lead to provider burn-out and fatigue, as the number of providers willing to do pro bono work are much fewer than the increasing number of uninsured and underinsured refugee patients. Furthermore, depending on the generosity and commitment of volunteer health care providers is an unsustainable system level solution to providing health care.

With the tiered IFH system, many hospitals have been absorbing the costs for uninsured refugee patients' treatment, while simultaneously billing them. The number of refugees able to afford out-of-pocket payments is not known, although likely very few.

At a policy level, Toronto introduced the Sanctuary City plan on February 21, 2013 becoming the first Canadian city with a formal policy allowing undocumented migrants to access municipal social services regardless of their immigration status. The rationale of the "don't ask don't tell policy" is for the undocumented and those with precarious legal status to be confident that city agencies will deliver social services in safe and inclusive environments.

Conclusion

Opportunities For Action

Some of the systemic barriers identified in this report are not new. However, any barriers and negative impacts assume an added urgency given the greater vulnerability of refugees with the revised IFH program. This report's findings indicate that a standard approach for serving uninsured and underinsured refugee patients and dealing with the IFH administrative complexity is absent. Despite this, many policy analysts and service providers have made recommendations about how health care providers and governments can ensure that all refugees have better access to care. There are, however, risks associated with not having solid information on the IFH cuts impacts, and these must be taken into consideration when planning for refugee health care policy and programming.

Action At The Provincial Level

The situation at the provincial level is complex and varies among the different provinces. With the aim of addressing and reducing the gap in health coverage for refugee claimants, action has been taken in Alberta, Manitoba, Saskatchewan, Nova Scotia, Ontario and Quebec so far.

In September 2012, Quebec had over 15,250 people with IFH program coverage, including about 6,000 with Public Safety Health Care coverage.⁴⁰ Quebec provides full medical, diagnostic and hospital coverage

⁴⁰ These figures are based on an Access to Information request from the CIC.

for failed claimants and DCO claimants with the Public Safety Health Care coverage.⁴¹ This means that in Quebec, all refugee claimants have exactly the same access to health care, irrespective of whether they have the IFH Health Care or Public Safety Health Care coverage. The principal difference between the two categories of coverage pertains to billing, but there is no difference in entitlement to services. Thus, in Quebec all refugee claimants, from the time they make their claim until the their case is resolved, have health care coverage that is similar to provincial health insurance, with a single exception that fertility treatments are not covered.

Although the Quebec government does not cover dental or eye care, it does cover rehabilitation, contraception, and sterilization, which are no longer covered by the federal government even for refugees with Health Care coverage. With regards to mental health, refugee claimants have the same access as Quebec residents to free psychotherapy, i.e. by getting on the waiting list for psychologists working in community health clinics. Psychiatric care is covered because it is a medical service. In addition, all refugee claimants, irrespective of the type of IFH coverage, have the same access to prescription drugs as do other Quebec residents — either through social assistance or through the Quebec Public Prescription Drug insurance.

Health care providers have found that despite Quebec’s government’s undifferentiated health care program for refugees, refugee claimants still have problems accessing health care services because providers are often unaware of this current health care program.

In Ontario, on January 1, 2014 the Ministry of Health and Long-Term Care launched the new Ontario Temporary Health Program (OTHP) for refugee claimants who are not eligible for health care under the new federal rules or through other government programs.⁴² Through this temporary provincial program, DCO claimants and rejected claimants (who are not yet under an enforceable deportation order) will be able to access most primary care and urgent hospital services. In terms of medication coverage, all individuals with either IFH Health Care coverage or Public Health Safety coverage will have medication coverage equivalent to the Ontario Drug Benefit. Thus all refugee claimants will have the equivalent of IFH Health Care coverage, which is itself very similar to OHIP coverage. To be eligible for OTHP, refugee claimants are subject to a three-month wait period which would start the day the refugee claimants application is accepted by Citizenship and Immigration Canada, and as indicated by the date the federal identification card is issued, with the exception of:⁴³

- Children under the age of 18;
- Women requiring perinatal and prenatal care; and
- Individuals with a life-threatening condition, as defined through the federal program.

The OTHP is very similar to Quebec’s refugee health care program, but the Quebec program is more generous as there is no waiting period. It is worth noting that the Quebec program was instituted at the time of the federal cuts (June 2012), although there are still challenges with its implementation.⁴⁴ There

41 Grateful to Janet Cleveland for providing details on the Quebec government’s health care program for refugee claimants.

42 Reinstating Access to Health Care for Refugee Claimants - Ontario Filling Federal Funding Gap with Temporary Health Program, December 9, 2013, http://news.ontario.ca/mohltc/en/2013/12/reinstating-access-to-health-care-for-refugee-claimants.html?utm_source=ondemand&utm_medium=email&utm_campaign=p.

43 For further details about refugee claimant eligibility to OTHP, refer to the Ontario, Ministry of Health and Long-Term Care, December 2013 notice.

44 Based on feedback from service providers using the Quebec’s government refugee health care program .

are several reasons for provinces and territories to follow Quebec's lead in providing provincial-level coverage to all refugees regardless of category. Most importantly, provinces will eventually have to cover the costs resulting from delayed health care and untreated conditions. Therefore, providing provincial-level coverage moves from ad hoc responses towards a system level solution.

It is important to note that historically health care services in Canada have been a provincial responsibility. As such, provincial health ministers and other provincial actors have the experience and technical expertise required to deal with this specific policy sector. They are thus strategically placed to be champions of policy reform in the IFH context.

Action At The Federal Level

At the policy level, any changes to IFH need to be carried out at the federal level as the IFH program portfolio falls under federal mandate. A common theme from this study and other providers' sources is that, to undo the current damage, the federal government needs to reverse the cuts.⁴⁵ The federal government's use of xenophobic language for refugees, such as "bogus" and "abusers" of the Canadian health system, creates ideological barriers to policy change.⁴⁶ Instead, health policies need to be evaluated from a public health perspective.

Citizenship and Immigration Canada need to collaborate with service providers and frontline workers to build on what is already working in terms of ensuring health care access to refugee clients and mitigate the arbitrary and inequitable ways in which IFH program is being administered. This will help to better regularize the status and treatment of all refugees across Canada.

Strengthening Community Health Centres

At the health care system level in many provinces, CHCs provide a comprehensive range of health services and are particularly important for people living in poverty or who have limited to no health coverage. In Ontario, CHCs are well-placed to provide care to uninsured refugees because they are provided with certain funding from the province to provide services for uninsured clients. However, the Ministry of Health and Long-Term Care needs to assess if current funding is adequate for CHCs to enhance their ability to provide continued assistance to refugees, in addition to other vulnerable populations.

While increasing CHC capacity is generally recommended, in the long-term this may reinforce the federal government's disengagement with the increasing number of uninsured and underinsured refugees. Because CHCs are mandated to function at a community level and are not equitably available across the country, this cannot have a pan-Canadian impact. Increasing capacity in community clinics can make a crucial immediate difference to vulnerable populations, but is not, in and of itself, a long-term sustainable

45 The Wellesley Institute set out a range of actions at the federal, provincial/territorial, regional health authority and service provider levels. See 'Actions to address the impact of cuts to refugee health benefits for details', <http://www.wellesleyinstitute.com/news/actions-to-address-the-impact-of-cuts-to-refugee-health-benefits/>.

46 CBC News, Refugee health wrong priority for provinces, Kenney says, June 22, 2012 <http://www.cbc.ca/news/politics/story/2012/06/29/polkenney-refugee-health.html>

solution.

Enhancing Collaboration To Ensure Support For Pregnant Refugee Claimants

In Ontario uninsured pregnant claimants are increasingly being served by midwives, as midwives are funded to provide care for non-insured clients. However, midwife clinics are at risk of becoming overburdened due to refugees being turned away from obstetrician and hospital care.

One solution is greater coordination between CHCs and midwifery clinics to serve all uninsured persons within their catchment area. Given that CHCs and midwifery clinics in Ontario are funded to care for all residents, regardless of insurance status, establishing formal collaborative partnerships between the two institutions would be a means to build capacity to ensure pre/post natal assistance is made available.⁴⁷

Regular Evidence Gathering, Monitoring And Evaluation Of IFH Program Impacts

Systematic evidence gathering of refugee health cases helps to build data that can be used to monitor and evaluate outcomes of the revised IFH program. Canadian Doctors for Refugee Care developed an online data submission portal called the “Refugee Health Outcome Monitoring and Evaluation System.” Its purpose is to record and track adverse health consequences occurring in refugee patients. This is not meant to be rigorous research, rather it serves as a means to demonstrate the scope of problems (health, economic, and social in nature) that have arisen due to restricted to no health care access to certain refugee categories.

Another on-going research project is the “Accessibility and Costs of Health Care for Refugee Claimants following Changes to the Interim Federal Health Program,” which is 3.5 year multi-site study involving over 40 health care institutions in Toronto and Montreal.⁴⁸ The study aims to assess the impact of the IFH program cuts on refugee claimants’ access to health care and the cost of providing care, and to improve refugee claimants’ access to health care. The data will serve as a basis for policy proposals to government and institutional decision-makers, as well as for information campaigns and scholarly publications.

There are some unique challenges to collecting refugee health qualitative and quantitative evidence. Providers have documented that only a limited number of refugee claimants’ show up at clinics and this due to several reasons including, fear that their claim may be rejected leading to future deportation, worry that they may not be able to pay for services, are unsure of their coverage eligibility, are unaware of social services and how to navigate the health care system. Consequently, patients that do show up to clinics and receive medical assistance are often the most vulnerable; very sick and more desperate ones. This likely represents only a small proportion of refugees whose health circumstances and stories can be formally recorded. In reality, there remain an unknown number of failed refugee claimants, who have stayed after their deportation date, i.e. after they have become non-status. The trajectories of health care

⁴⁷ Example of such collaborations, see Midwives and LAMP birth new partnership, http://www.aom.on.ca/files/Communications/Midwifery_in_the_News/ExcerptAOHCSynergyWinte2012.pdf.

⁴⁸ Based on information provided by the National Project Manager.

issues and use of services for these refugee claimants remain, however, largely undocumented. As a result, calculating the true extent of the revised IFH program impacts on refugees is difficult and data collected from providers will represent only a limited sample. Some study participants noted that evidence gaps on Canada's newcomer population have further deteriorated with the elimination of the long-form census in 2010, which historically provided some (although limited) insight on trends in settlement services and policies for refugees and migrants.

Despite these limitations, efforts to increase evidence gathering on refugees' health needs is necessary to carry out policy evaluations on sector specific impacts. For example, policy makers need to know the cost/benefit implications of using emergency room and acute care staff to treat primary health care concerns and, how many patients come in through emergency departments. This will help to address the surge in emergency room use and to design innovative specialized clinics to cater specifically for treating refugee clients. Finally, this report highlights that evidence is also needed from the perspective of service providers; the provision of care for uninsured and underinsured claimants' draws upon clinical resources, generating an additional workload that has ultimately has implications for the operating costs for clinical services.