Access to Health Care for Refugee and Refugee Claimants in Canada

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Policy Issue

- In 2012, the federal government dramatically decreased their funding for the Interim Federal Health Program (IFHP), preventing many refugees and refugee claimants from equitable healthcare access, resulting in adverse health outcomes.

Context

- Evidence has consistently shown that refugees are a vulnerable population with multiple health risks [1]
  - Refugees have higher mortality and morbidity compared to the Canadian-born population [1]
  - Greater risk of experiencing mental health challenges [1]
  - Higher prevalence of infectious disease [1]
- Despite this, refugees under-utilize healthcare services [2]

Interim Federal Health Program

- The IFHP is a federally mandated temporary health plan for refugees and refugee claimants; it was implemented under an Order-in-Council in 1957.[1]
- Historically, all refugees, refugee claimants, and people with unsuccessful refugee applications obtained basic coverage and supplemental coverage through IFHP.[3]
- Services available included primary and hospital care, as well as supplemental benefits including: pharmaceutical, dental, vision, prenatal and obstetrical care.[3]

Balanced Refugee Reform Act, 2010: Creating Designated Countries of Origin

- Designated countries of origin (DCOs) are countries that "do not normally produce refugees, but do respect human rights" and are determined by the Minister of Citizenship and Immigration.[4]

Reformed IFHP

- In 2012, an amendment was made to the 1957 Order-in-Council [1]
- Three classifications of health care are now available for refugees (Table 1)

Table 1: 2012 IFHP Coverage [5]

1) ***Expanded Health-Care Coverage*** is provided to Government Assisted Refugees; identical to the pre-2012 reforms coverage.
2) ***Health-Care Coverage*** is provided to Privately Sponsored Refugees and non-DCO claimants; includes primary and hospital care.
3) **Public Health or Public Safety Health-Care Coverage** is provided to DCO claimants and rejected refugee claimants. No healthcare is provided unless required to treat a disease posing a public health risk.

Multi Goal Analysis of IFHP

	IFHP	2012 Reformed IFHP
Efficiency I. Cost of providing health care II. Overall morbidity and mortality III. Efficiency of the refugee determination system	(1) Access to preventive and primary care will not only improve the health of refugees and refugee claimants, it will also reduce the likelihood that they will have to access more costly emergency care services in the long-term. (2) By promoting the health of refugees and refugee claimants, we may be promoting the health of future Canadians and, by extension, their social and economic integration (*e.g.* labour market activity). (3) It may encourage fraudulent refugee claimants by offering benefit incentives.	(1) The costs associated with the IFHP doubled from $50 million in 2002 to $91 million in 2010. By limiting the scope and generosity of the program, the federal government anticipates it will be saving tax payers $20 million annually. (2) The restrictions will encourage refugees and refugee claimants to delay seeking care until their health deteriorates to the point that they are forced to visit hospital emergency departments and receive care for acute conditions that could have been prevented at a much lower cost through primary care. Any anticipated savings at the federal level will, in effect, represent a downloading of inflated costs to the provincial level. (3) It may discourage fraudulent refugee claimants by removing benefit incentives.
Equity I. Fairness to the refugee population II. Fairness to the broader public	(1) Promotes equality among refugees and refugee claimants by awarding a uniform level of coverage. (2) Promotes equity by providing coverage for supplemental benefits (*e.g.* dental and vision care). Low-income Canadians have access to supplemental benefits through their provincial health insurance plans. Refugees and refugee claimants are disproportionately affected by poverty. Just as we recognize the barriers to supplemental care experienced by low-income Canadians, this policy option recognizes the barriers experienced by refugees and refugee claimants. Conversely, those refugees who may be able to afford private supplemental insurance will be benefitting from access to publicly funded services that are not readily available to most Canadians. (3) As tax payers, Canadians are funding a system of benefits for which they are ineligible.	(1) As tax payers, refugees and refugee claimants will be denied access to a publicly-funded system that they are paying into. (2) New inequalities within the refugee population will result. Whereas the previous system awarded a uniform level of coverage to all refugees and refugee claimants, the new tiered system awards different levels of coverage to different categories of refugees and refugee claimants. (3) Greater inequities between refugees and the Canadian population will result. Failed claimants and claimants arriving from DCO countries no longer have access to basic health services. (4) Greater equality between refugees and the Canadian population may be promoted. With the new system, the majority of refugees and refugee claimants no longer have access to supplemental benefits (*e.g.* dental and vision care) that are not available to most Canadians through provincial health insurance plans.

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References: For a complete list of references, please contact one of the members of the research pod listed above.