Enter at your own risk: government changes to comprehensive care for newly arrived Canadian refugees

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On June 30, 2012, most refugees to Canada, including those who arrive seeking asylum, had major cuts to health insurance coverage provided by the Interim Federal Health Program. Coverage for many is now limited to conditions deemed a public health or public security concern.

At the eleventh hour, following unprecedented activism by health care providers, editorials from national newspapers and letters from medical associations, refugees sponsored by the government and certain privately sponsored refugees were excluded from the cutbacks. In the succeeding 2 months, confusion has reigned among refugees and providers, with eligible refugees requiring urgent care being turned away from emergency departments while the government partially reverses course.

Canada's role and programs

The 1951 United Nations Convention Relating to the Status of Refugees defines refugees as people in need of protection because of a "well-founded fear of being persecuted."[1] Canada accepts about 25 000 per year and, as a signatory to this convention, the Constitution of the World Health Organization and the Universal Declaration of Human Rights, should guarantee such refugees the universal right to the highest attainable standard of health in this country.[2]

Since the Immigration and Refugee Protection Act in 2002, refugees invited by the Government of Canada or some private groups typically arrive sicker and with less social capital to be self-sufficient than before the act, because of the priority placed on resettling vulnerable refugees who need urgent protection. These refugees receive residency status on arrival, have access to basic provincial health insurance programs, may also qualify for income support, and, thanks to the government's capitulation, will continue to receive extended health coverage.

However, most refugees sponsored by private groups and all refugee claimants — people who have found their way to Canada on their own and make a claim for refugee status — will be affected by the revised Interim Federal Health Program. In 2011, a total of 24 900 people made requests for asylum from within Canada.[2] The government now divides refugee claimants into 2 categories: those from designated countries of origin (countries the government determines to be generally safe and should not be producing people in need of protection) and those from other countries. At the time of this article's publication, the list of designated countries of origin is still not available.

Under the revised program, Citizenship and Immigration Canada describes 4 categories of insurance: health care coverage, expanded health care coverage, public health or public safety health care coverage, and no coverage.[3]

Refugee claimants who arrived from a designated country of origin before June 30, 2012, including most privately sponsored refugees and successful claimants, will lose insurance for medications, prosthetics, assistive devices, and emergency dental and vision care. Only medications prescribed to prevent or treat a public health threat will be covered.

People whose refugee claims have been rejected and those arriving from a designated country of origin after June 30, 2012, will have even less coverage: they will receive health services only if their condition poses a risk to public health or is a public safety concern. Risks to public health are defined by the Public Health Agency of Canada as diseases capable of human-to-human transmission or for which vaccinations are recommended. Public safety con-

Key points

- The federal government has implemented legislation diminishing its responsibility for the health of certain newly arrived refugees.
- Access to health insurance for medications, prostheses, emergency dental and vision care, and translation services is now limited for most refugees.
- Many refugee claimants will be denied all health coverage, including coverage for emergencies.
- The changes shift health care costs to vulnerable refugees, provincial health plans and health care providers.

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cerns are defined as mental health conditions for which a physician believes that the person will likely cause harm to others; conditions for which there is a risk of self-harm are not included.

Challenging government assertions

The federal government claims that the changes to health services for refugees will discourage fraud, save money in the long term and ensure fairness.[4] We challenge these assertions.

Countries around the world are exploring policy levers to deter undesirable migrants. In Europe, however, restricting access to health care as one such measure has had limited success.[5]

Citizenship and Immigration Canada reports that the cost of the Interim Federal Health Program in 2011 was $84.6 million.[4] The annual cost of coverage per refugee under the program may be somewhere between $562 and $660, substantially less than the $6141 spent per capita on health and social services for the average Canadian.[6] Despite last-minute adjustments to eligibility, the government continues to assert that scaling the program back will result in a 5-year savings of about $100 million; however, no economic analysis has been released to substantiate this claim.

We question this assertions, as savings from denying medication under the Interim Federal Health Program may increase costs to provincial health care systems, which cover emergency department visits and complications that arise from unaddressed medical needs.

Another rationale for the cuts is to ensure that refugees receive no more care than that offered to Canadian citizens. To claim that other Canadians lack access to such extended care is disingenuous. Most provinces provide citizens of limited means with social assistance packages virtually identical to that provided under the former Interim Federal Health Program.

To deny access to basic health care for these future Canadians (about 30%–50% of refugee claimants will eventually become citizens[7]) is both inequitable and possibly inhumane in light of the extreme hardship and mistreatment many have already experienced. Herein lies the nucleus of concern by those expert in the short- and long-term consequences of intentionally or inadvertently introducing new system-level barriers to health care: there is now inequity where none existed before.

Consequences

One recent study involving government-assisted refugees arriving in Canada found that 60% had no English or French language skills; most had little formal education or work experience and would need to overcome individual, institutional and systemic barriers to access appropriate health care (unpublished observations, 2012). Poverty is widespread among a growing proportion if refugees.[8] The notion that refugees will purchase health insurance or pay for care themselves is fanciful. Yet with proper support, refugees do well and are healthy and employed.[9]

Providing vision care, for example, to Bhutanese refugee children facilitates educational success; providing prostheses to Afghan land mine amputees and Congolese machete victims improves employability. Withdrawing such supports increases social isolation and compromises physical and mental health.

The assessment and treatment of heart attacks, prenatal care, childhood illness and suicidal ideation are no longer covered for many refugees. When a person with uncontrolled diabetes ends up in the emergency department, or a pregnant patient unable to afford blood pressure medication prematurely delivers a baby who needs neonatal intensive care, Canadians will bear the burden of these policy changes through their taxpayer-supported provincial health plans. In addition, gatekeeping will fall to front-line providers such as hospitals and primary care physicians, as seen in other jurisdications.[10]

Our collective experience and empirical evidence suggest that the effects of this type of legislation will entrench inequities rather than address them, weakly address fraud and cost the health care system in the long run. The changes to the Interim Federal Health Program represent a profound shift in Canada's approach to migration and its humanitarian principles and obligations.

For references, see Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.120938/-/DC1

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