

# Effects of cutting refugee health benefits in Canada

Wendy Masinde and Jae-Yung Kwon

University of British Columbia

In 2012, reforms were made to refugee health benefits under the Interim Federal Health Program (IFHP) as a result of public discourse that cast these benefits as costly and unfair to Canadians.<sup>1</sup> IFHP benefits act as temporary health coverage until an individual becomes eligible for provincial or territorial health insurance, usually through acquiring permanent residency status.<sup>1</sup> Cuts to benefits affect refugees who arrive without government sponsorship. In 2012, there were 89,383 non-sponsored refugee claimants present in Canada.<sup>2</sup> Of the non-sponsored claimants arriving in Canada, only 38% of asylum claims were ruled to be legitimate and afforded permanent residency in 2011.<sup>1</sup> Under the new policies, privately sponsored refugees and individuals claiming asylum are not covered for services such as non-emergent hospital services, laboratory, diagnostic and ambulance services, prosthetic and mobility assistance coverage, psychological counseling, home care and long term care.<sup>1,3,4</sup> These changes will have a considerable effect on the health and well-being of refugees in Canada.

Cuts have been made under the assumption that continuing federal spending on refugee benefits is expensive and unfair to Canadian taxpayers.<sup>5</sup> New amendments to the IFHP shift the focus of refugee health care to the management of emergent conditions in favour of preventative health care. Relocating the majority of care provided to the emergency department is costly and shifts the financial burden to provinces and territories.<sup>1</sup> Emergency departments will also potentially see a rise in demand and an increase in already lengthy wait times. As such, there can be no advantage to limiting health coverage in this population.

These new policy changes deny people access to much needed health care; therefore, new strategies in primary health care delivery are needed to eliminate barriers and allow for better access to health services. In these strategies, the clinician would work to improve access to health care. Such strategies would include creating low barrier, non-

judgmental environments, providing care that makes patients feel welcome, and by forming partnerships with community organizations that can be used as resources.

## Barriers to Health Care

Refugees typically seek asylum from threats to their freedom or wellbeing and are already at a higher risk for poor physical and mental health at the time of their arrival.<sup>1,3</sup> Moreover, the refugees lack social support systems, familiarity with the health care system, and at times are unable to support themselves financially.<sup>1,6,7</sup> Additional barriers to positive health outcomes include limited employment opportunities, perceived discrimination from health care providers, language barriers, risk of exploitation, social isolation, and risk of experiencing violence and abuse.<sup>1,3</sup> Bureaucratic barriers create difficult situations where people are unable to seek the care they need, as in the case of an individual with chronic illnesses such as diabetes who require monitoring and regular medication for which they are not covered and have no alternative ways of payment.<sup>1</sup> Limited coverage can be a disadvantage, as uninsured individuals might face discrimination when accessing care, be denied care or avoid seeking care due to a lack of funds for payment or the additional administrative hurdles involved in such payment.<sup>1</sup> This could further contribute to higher rates of poor health outcomes already present within this population.<sup>3</sup>

## Strategies to Improve Health Care Access

Asylum claimants have limited access to structural support systems such as community clinics that are afforded to permanent and documented residents of the country.<sup>6,9</sup> A familiarity with refugee-specific resources should be incorporated into clinical practice to allow for the provision of comprehensive health services.<sup>7</sup> Clinic staff should also be available to help fill out forms that provide ►

supportive resources such as social assistance and housing. Resettlement services and local cultural communities could be potential partners who could aid in providing comprehensive services such as employment assistance, opportunities for forming social support, translation services and education.<sup>7-9</sup> Federal services and resources could be insufficient as they are often limited to refugees sponsored by the Canadian government.<sup>1</sup> In these cases, partnerships with non-governmental organizations that provide similar services need to be sought out. Payment policies should be expanded to allow for different forms of compensation and within acceptable periods of time.<sup>7</sup>

Elements of trauma- and violence-informed care (TVIC) as well as cultural safety can also be integrated into clinical practice.<sup>6,7,9</sup> TVIC involves understanding of the effects of trauma, working actively to foster trust and create a safe and validating health care environment, and working towards addressing the policy and structural conditions that influence health and social inequities in the context of the social determinants of health. Together TVIC and cultural safety have the potential to encourage healing, promote people's strengths and prevent the retraumatization that can often occur when people attempt to access health and

social services.<sup>6, 10</sup> Reaching out to the greater community for partnerships that cater to refugees' concerns would also fill this need.<sup>8, 9</sup> This could include the use of interpreters or cultural partners who can help identify culture-specific concerns and facilitate the inclusion of cultural beliefs and practices into health teaching and practices. These, in addition to informal networks such as religious organizations, ethno-cultural associations and networking groups could also be sources of social support.<sup>10</sup>

#### Future Directions and Conclusion

Refugees face numerous social and economic barriers to accessing health care. Reforms to the IFHP have led to cuts that have left some refugees unable to get coverage for health care. This compounds the systemic barriers they face when accessing primary health care. Additionally, these policy changes shift the care of refugees from preventative care to acute and emergency care organizations. Primary health care practitioners should consider providing comprehensive care services by making low-barrier organizational changes and partnering with community organizations in order to fill the gaps created by this deficit in care. ■



#### Wendy M. Masinde

Wendy M. Masinde is currently pursuing her MSc. in Nursing at the University of British Columbia. She received her BSN at Minnesota State University Moorhead in 2009. Her research focuses on health and healthcare inequities with an emphasis of the effect on intersecting social, economic and political axes in accessing health care and health resources. Her clinical background is in medical and surgical nursing.



#### Jae-Yung Kwon

Jae-Yung Kwon is a PhD student at the University of British Columbia in Nursing. His research focuses on developing policies and evaluative tools to improve performance of primary healthcare in Canada. He is currently the editor in the Health Professional Student Journal and works as a registered nurse in neuroscience.

## References

1. Barnes S. The real cost of cutting refugee health benefits: A health equity assessment 2012. Available from: <http://www.wellesleyinstitute.com/wp-content/uploads/2012/05/The-Real-Cost-of-Cutting-Refugee-Health-Benefits.pdf>.
2. Facts and figures 2012 - Immigration overview: Permanent and temporary residents: Government of Canada; 2012 [cited 2014 Mar 10]. Available from: <http://www.cic.gc.ca/english/resources/statistics/facts2012/temporary/26.asp>.
3. Brabant Z, Raynault MF. Health of migrants with precarious status: results of an exploratory study in Montreal--Part B. *Social work in public health*. 2012;27(5):469-81.
4. Interim federal health program policy: Government of Canada; 2012 [cited 2014 10 Mar]. Available from: <http://www.cic.gc.ca/english/department/laws-policy/ifhp.asp>.
5. News Release - Reform of the Interim Federal Health Program ensures fairness, protects public health and safety: Government of Canada; 2012 [cited 2014 10 Mar]. Available from: <http://www.cic.gc.ca/english/department/media/releases/2012/2012-04-25.asp>.
6. Pottie K, Batista R, Mayhew M, Mota L, Grant K. Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies. *Canadian family physician Medecin de famille canadien*. 2014;60(1):e32-40.
7. Browne AJ, Varcoe CM, Wong ST, Smye VL, Lavoie J, Littlejohn D, et al. Closing the health equity gap: evidence-based strategies for primary health care organizations. *International journal for equity in health*. 2012;11:59.
8. Simich L, Beiser M, Stewart M, Mwakarimba E. Providing social support for immigrants and refugees in Canada: challenges and directions. *Journal of immigrant health*. 2005;7(4):259-68.
9. McMurray J, Breward K, Breward M, Alder R, Arya N. Integrated Primary Care Improves Access to Healthcare for Newly Arrived Refugees in Canada. *Journal of immigrant and minority health / Center for Minority Public Health*. 2013.
10. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. *Can Med Assoc J*. 2011;183(12):E824-925.