COMMENTARY

Interim Federal Health: A Public Health Perspective

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A 34-year-old refugee claimant presents in your office. She escaped from Columbia three years ago and claimed refugee status immediately on arrival to Canada. After being given Interim Federal Health (IFH) insurance coverage, she was unable to find a family physician who would accept it. She went for 18 months without primary care, and had to go to the emergency room several times due to complications of her type 1 diabetes. Still waiting for her refugee status hearing, she recently started receiving care from you at a Community Health Centre. She is now pregnant, and her referrals to obstetricians have been refused several times due to her IFH coverage.

This case is a representation of the experiences of refugees in Canada. Often fleeing from trauma, poor living conditions or little access to health care, some refugees have difficulty getting their frequently complex and pressing health care needs met upon arrival. The Interim Federal Health (IFH) Program, federal health insurance extended to refugees on arrival in Canada, does not adequately address the needs of these populations. Allowing refugees to go without adequate care is irresponsible from the point of view of individual health status. Examined more broadly, however, these health inequities are equally problematic from a public health standpoint. Public health depends on health equity, the prevention of illness, the promotion of health and the health status of the entire population. Using these principles to guide an analysis of IFH, it appears that public health is compromised by this program that limits access to health care and acts as a structural barrier to health.

Key Points

- The Interim Federal Health (IFH) Program is health coverage provided to refugees upon arrival in Canada.
- Limitations of this program include lack of coverage for routine and mental health care, resulting in a structural barrier to health.
- Limiting access to preventive medicine and primary care leads to health inequities, which in turn compromise public health.
- Health policies regarding refugees should therefore be evaluated from a public health perspective, ensuring equitable access to comprehensive primary and preventive health care, regardless of political status.

BACKGROUND

Refugees are defined by the United Nations High Commission on Human Rights (UNHCR) as persons who are unable to return to their country of origin for fear of persecution based on race, religion, nationality or membership of a particular social group or political opinion.[1] There are two main classes of refugees living in Canada: Convention refugees and refugee claimants. Convention refugees (referring to the 1951 UN Convention on Refugees) live outside their home country, frequently in refugee camps, and are chosen by the UNHRC for resettlement in Canada. In contrast, refugee claimants are persons in need of protection who make their way to Canada independently and claim refugee status upon entry or shortly thereafter. While Convention refugees are considered permanent residents immediately upon arrival to Canada, refugee claimants are considered temporary residents until their application is approved by the Immigration and Refugee Board (IRB).[2] In 2008, 20,860 Convention refugees were resettled in Canada, in addition to 36,851 individuals who claimed refugee status.[3]

Both of these groups are immediately covered by IFH. Introduced by the federal government in 1957, IFH is meant to cover “emergency and essential health coverage” before refugees are considered permanent residents and become

eligible for provincial health insurance.[4] It provides essential health services for serious medical or dental conditions, contraception, prenatal and obstetrical care and essential prescription medications. Routine examinations and treatment are not included, nor is care for non-acute mental illness.[5]

In Ontario, Convention refugees are immediately eligible for the Ontario Health Insurance Program (OHIP) and therefore rely on IFH for a short time only. Refugee claimants, however, remain covered by IFH until their claim has been settled, which can amount to a considerable length of time given the significant backlog experienced by the IRB.[6] Estimated delays vary from an average of 14 months to 5 years or more, with immigration appeal taking an average of 11 months.[6,7] Refugee claimants, therefore, are more significantly affected by the limitations of IFH than Convention refugees.

REFUGEE HEALTH

The precarious health status of both refugee claimants and Convention refugees makes adequate access to health care a public health imperative, and underlines the need for comprehensive care. While they are not a homogenous population with regards to previous health status, refugees have higher mortality rates than non-refugees.[8] Refugees often come from countries with serious internal conflicts and many have experienced significant trauma, which can lead to mental health problems.[9] In the past, estimates of the percentage of refugees who have experienced torture, a common cause of post-traumatic stress disorder (PTSD), have ranged from 1 to 37% in some groups.[9] An increased rate of depressive disorder and PTSD has been noted in many groups, including Kosovar and South Asian refugees.[7,10,11]

Infectious diseases are also more common in refugee populations. The vast majority of cases of tuberculosis are experienced by foreign-born individuals, including refugees, and this proportion is rising, with 33% of active TB cases occurring in the first two years following arrival.[12-14] In addition, high prevalence rates of intestinal parasites, hepatitis B and HIV infection among refugees have been noted.[9,15,16]

These finding are significant considering that refugees are generally young populations. Eighty-seven percent of refugee claimants in 2008 were less than 44 years of age.[3] Children are particularly vulnerable to these health problems, especially mental illness.[7] Considering that childhood development (including health and access to both dental and medical care) is identified by the Public Health Agency of Canada as one of the social determinants of health,[17] these health challenges have significant import for the future health of Canadians.

LIMITATIONS OF IFH

Immediate access to comprehensive medical care is clearly an urgent need for refugees arriving in Canada. While there are few studies directly comparing health outcomes of refugee populations with differing health care coverage, access to healthcare is a significant social determinant of health in all populations.[17] As a structural barrier to health care access, IFH acts as a barrier to the attainment of positive health outcomes.

IFH does not cover routine visits to health professionals,[18] and a lack of routine primary care precludes the possibility of preventive medicine and the promotion of healthy lifestyles for refugees as they attempt to adapt to new ways of life. It also does not cover care for mental illness, except in emergency situations,[5,19] which is particularly problematic given the high prevalence of PTSD. Other conditions would also benefit from increased screening and early intervention, including latent tuberculosis infection[13] and cervical cancer.[11] An examination of health outcomes determined that care in the first period of residence is particularly important to reducing illness,[16] which is precisely when access to health care is restricted. Furthermore, lack of access to primary care forces patients to frequent emergency rooms for non-emergent care at a great cost to the health care system.[18,20] This lack of coverage is made more urgent when considering that refugee claimants can spend up to five years without access to routine primary care while waiting for their claims to be processed.[7] Bureaucratic delays in processing applications for IFH coverage have also been reported, leaving some refugees with no access to care for significant periods of time.[19]

IFH is also burdensome for health care providers to utilize,[18] leading physicians, both family doctors and specialists, to deny treatment.[20] While we must critically examine the ethics of denying treatment based on health coverage, several barriers have been noted by physicians, including the billing requirements, cumbersome paperwork and slow reimbursement.[19]

DISCUSSION AND CONCLUSION

IFH is a major barrier to health equity, positive health outcomes, preventive medicine and health promotion, which all have significant impacts on public health. Many suggestions for the improvement of IFH have been proposed.[18-20] These include an increase in the range of services covered by IFH to encompass routine primary care, more timely access to care for mental illness, better dental coverage, expedition of the IRB process, a reduction of bureaucratic delays in processing IFH applications, and streamlining of the payment process to decrease barriers faced by health providers. These concrete recommendations would certainly improve access to health care by refugees if adopted and therefore merit serious consideration by policy makers.

Another alternative would be to integrate refugees fully into the mainstream health care system by extending provincial insurance programs to all newly arrived refugees, including refugee claimants. This, however, may also prove problematic, as what IFH lacks in depth and comprehensiveness, OHIP lacks in breadth of services, including dental care, eye

care and prescription medications. Given their health status and economic need, many refugees need more than either IFH or OHIP can offer independently. The solution therefore lies in either making the changes to IFH outlined above to improve its depth of services, or extending provincial coverage such as OHIP to all refugees, while broadening the services to include increased coverage of prescription medications, dental and eye care. A broadening of provincial coverage would benefit not only refugee populations, but also the population as a whole. Indeed, access to health care is not a challenge exclusively faced by refugees, and an investment in refugee health should not preclude investment in health equity for other marginalized populations in Canada.

The increased demand on resources in order to increase health coverage is one of many important considerations. There has been an increased emphasis placed on preventive and comprehensive primary care as a means of decreasing the financial burden of chronic disease in Canada,[21] and investing in comprehensive care for refugees may have a positive financial impact on Canada's health care system. Conversely, it has been noted that evidence does not always support the financial benefit of preventive and comprehensive medicine initiatives.[22] While there is still disagreement regarding the economic benefits of comprehensive and preventive medicine, it would be a mistake to overstate the importance of economic concerns. Healthier lives are justification enough for reasonable investment in equitable and comprehensive access to health care for refugees. While a more detailed economic analysis is outside the scope of this article, such investment is not without precedent; in the Netherlands, asylum seekers immediately have access to the same health care offered to nationals, which includes all physician and hospital services, preventive care, home care, dental care and pharmacare.[19]

It is also necessary to critically examine the conceptual foundations of our refugee system as a whole. Refugees are often viewed as outsiders, and dismissed as an excessive financial burden; IFH is one among many manifestations of these attitudes. We must remind ourselves that public health cannot be seen as solely the health of a country's citizens or native-born populations, and it would be unwise to allow political distinctions such as citizenship or refugee status to obscure that perception. While this is clearly recognized by many public health agencies that extend services and disease surveillance to refugees and non-status residents, governmental policy continues to shut refugees out of the mainstream health care system by underfunding and limiting access to health services through IFH. A re-examination of such policies through the lens of public health, relying on principles such as health equity, the prevention of illness and the promotion of health, would be a valuable approach to promoting the collective health and well-being of the entire population, regardless of the political status of individuals.

REFERENCES

1. United Nations High Commission for Refugees (2004). Resettlement Handbook. Retrieved February 28, 2010 from the World Wide Web: http://www.unhcr.org/cgi-bin/texis/vtx/search?page=search&docid=46f7c0ee2&query=resettlement%20handbook
2. Citizenship and Immigration Canada (2008). The refugee system in Canada. Retrieved February 28, 2010 from the World Wide Web: http://www.cic.gc.ca/english/refugees/canada.asp
3. Citizenship and Immigration Canada (2008). Facts and Figures 2008: Immigration Overview – Permanent and Temporary residents. Retrieved February 28, 2010 from the World Wide Web: http://www.cic.gc.ca/english/resources/statistics/facts2008/index.asp
4. FAS Benefit Administrators, Ltd (2006). Interim Federal Health Program: Information Handbook for Health-care Providers. Retrieved February 28, 2010 from the World Wide Web: http://www.fasadmin.com/IFH%20Client%20Info%20english.asp?language=english&page=pdf
5. Yu S, Ouellet E, Warmington A. Refugee integration in Canada: A survey of empirical evidence and existing services. Refuge 2007; 24: 17-34.
6. Immigration and Refugee board of Canada (2008). Departmental Performance Report 2007-2008. Retrieved February 28, 2010 from the World Wide Web: http://www.tbs-sct.gc.ca/dpr-rmr/2007-2008/inst/irb/irb00-eng.asp
7. Canadian Mental Health Association (2003). Immigrant and Refugee Mental Health. Retrieved February 28, 2010 from the World Wide Web: http://www.cmha.ca/bins/content_page.asp?cid=7-13-858-859-885&lang=1
8. DesMeules M, Gold J, Kazanjian A, et al. New approaches to immigrant health assessment. Can J Public Health 2004; 95: I22-26.
9. Thonneau P, Gratton J, Desrosiers G. Health profile of applicants for refugee status (admitted into Quebec between August 1985 and April 1986). Can J Public Health 1990; 81: 182-86.
10. Beiser M, Turner RJ, Ganesan S. Catastrophic stress and factors affecting its consequences among Southeast Asian refugees. Soc Sci Med 1989; 28: 183-95.
11. Redwood-Campbell L, Thind H, et al. Understanding the health of refugee women in host countries: Lessons from the Kosovar re-settlement in Canada. Prehosp Disaster Med 2008; 23: 322-27.
12. Menzies D. Tuberculosis crosses borders. Int J Tuberc Lung Dis 2000; 4: S153-59.
13. Levesque JF, Dongier P, Brassard P, et al. Acceptance of screening and completion of treatment for latent tuberculosis infection among refugee claimants in Canada. Int J Tuberc Lung Dis 2004; 8: 711-17.
14. Nguyen D, Menzies D. Diagnosis and treatment of latent TB infection. Can J of CME 2001; May: 89-97.
15. Burnett A & Peel M. Health needs of asylum seekers and refugees. Br Med J 2001; 322: 544-47.
16. Dillmann E, Pablo R, Wilson A. Patterns of health problems observed among newly arrived refugees to Canada. In: Masi R, Mensah L, McLeod KA, eds. Health and Cultures. Exploring the Relationships (Programs, Services and Care). Vol 2. Oakville, ON: Mosaic Press; 1993. p. 253-58.
17. What determines health? [Internet] (2001). Public Health Agency of Canada. Retrieved February 28, 2010 from the World Wide Web: http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php
18. Steele LS, Lemieux-Charles L, Clark JP, et al. The impact of policy changes on the health of recent immigrants and refugees in the inner city: A qualitative study of service providers' perspectives. Can J Public Health 2002; 93: 118-22.
19. Gagnon AJ. Responsiveness of the Canadian health-care system towards newcomers. Discussion Paper No. 40. Ottawa, ON: Commission on the Future of Health Care in Canada; 2002. Retrieved February 28, 2010 from the World Wide Web: http://dsp-psd.pwgsc.gc.ca/Collection/CP32-79-40-2002E.pdf
20. Miedema B, Hamilton R, Easley J. Climbing the walls: Structural barriers to accessing primary care for refugee newcomers in Canada. Can Fam Physician 2008; 54: 335-36.
21. Kirby M, LeBreton, M. The Health of Canadians: The Federal Role – Interim report, Volume Six, Recommendations for Reform. Ottawa, ON: Standing Senate Committee on Social Affairs, Science and Technology; 2002.
22. Cohen JT, Neumann PJ, Weinstein MC. Does preventive care save money? Health economics and the presidential candidates. New Engl J Med 2008; 358: 661-63.

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