

A Critical Look at Refugee Healthcare in Canada: Recommendations to Improve the Interim Federal Health Program

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Abstract

The Interim Federal Health Program (IFHP) was initiated in 1957 by the Canadian government to provide basic health insurance for refugees and refugee claimants. After a series of budget cuts in 2012 and reinstatement of services in 2016, the IFHP has been met with confusion by healthcare professionals. Complex administrative processes have led to reluctance in providing care for refugees, including refugee claimants, by various healthcare providers. Refugees already face several barriers that hinder their ability to access care. Given the lack of awareness around the IFHP amongst professionals, this paper outlines recommendations and actionable steps for various key stakeholders to improve their knowledge of and commitment to the IFHP. Potential strategies include advocating for a simplified administrative process, holding government officials accountable for poor policy implementation, and enlisting the help of civil society organizations to raise awareness about the IFHP. These interventions are the first step in ensuring that the values of equity and multiculturalism are embraced in the healthcare system.

Keywords: refugee health, minority health, health policy, recommendations

Background

Across the world, millions of refugees leave their homes in search of new ones, free from slavery, war, and persecution. Canada has been at the forefront of providing a safe haven for many refugees over the decades (1). In 2019 alone, there were over 60,000 people that claimed refugee status in Canada (2). The Interim Federal Health Program (IFHP) was initiated in 1957 to provide basic health insurance for the vulnerable refugee and refugee claimant populations. The IFHP covered basic healthcare (i.e., in-patient and out-patient care, services from licensed healthcare professionals in Canada, and limited prescription drug coverage) for refugees and refugee claimants in the period before they received full provincial healthcare support (3).

As of 2012, large cuts to the IFHP services and budget were introduced by the Canadian Conservative government, which severely impacted the coverage of crucial healthcare services for many refugees and refugee claimants. The IFHP cuts prevented many refugees with chronic and life-threatening conditions from receiving medication and care for their treatment (4). These cuts were deemed to be in violation of

the Canadian Charter of Rights and Freedoms and were seen to be a consequence of the othering narrative constructed towards refugees by government officials and media sources (4). In response to reduced funding and cuts in IFHP services, many healthcare workers and civil society organizations (CSOs) such as Canadian Doctors for Refugees (CDR) and Canadian Council for Refugees (CCR) launched nation-wide protests and legal challenges to the federal government (5). In response, some changes such as cuts to supplementary care (i.e. vision and dental services) and the IFHP's limited drug coverage were reversed in 2014, leaving behind an aftermath of confusion among healthcare workers, organizations, and refugees themselves about the workings of the program (6).

Key Stakeholders involved with IFHP

When analyzing the IFHP, it is important to consider the role of different stakeholders in this program. From previous research, four main groups of stakeholders have been identified (5):

1. Refugees:

Refugees are people who are forced to flee from persecution and who are located outside of their home country. Refugee claimants are people who are asking for protection, but their refugee status has not yet been decided by the Immigration and Refugee Board (IRB) (7). For the purposes of brevity referring to the research in this paper, we will be using the term refugees to refer to all of these populations homogeneously. These groups of individuals generally have poorer health statuses, often having various acute and chronic diseases like malaria, hepatitis, nutritional deficiencies, diabetes, and hypertension (8). However, their access to healthcare is dependent on the practitioner's knowledge of the IFHP, not by their need for it. Refusal of practitioners to treat refugees not only leads to poor health outcomes in the short-term, but also has a long-lasting impact on the patients, such as making them less likely to seek out help from practitioners in the future (9).

2. Healthcare Professionals

Healthcare professionals have a duty to treat patients in need of urgent care regardless of their country of origin, residency status, or their ability to pay (10). However, in practice, this does not seem to be the case. To cater to patients that are covered by the IFHP, healthcare professionals must first become registered providers under Medavie Blue Cross (MBC), an insurance company that administers governmental programs. At each visit, professionals must ensure that patients are covered by the IFHP by verifying documentation such as the Interim Federal Health Certificate of Eligibility (IFHC) or a Refugee Protection Claimant Document (RPCD) (11). If this documentation is not provided or if patients have any private insurance that can cover even minimal costs associated with healthcare, they are considered ineligible for the IFHP and would have to pay for services out-of-pocket. Once they pay out-of-pocket, there are currently no systems in place for MBC to reimburse the patients directly for the cost of these services. If patients are deemed eligible, healthcare providers must submit claim forms to MBC within six months of providing services to receive reimbursements for their services, a process that can take another month. The additional paperwork and time commitment involved in registering for the IFHP, along with waiting to receive reimbursement, has resulted in some clinics refusing patients with IFHP coverage (12).

This reluctance to provide care has only been compounded by a lack of comprehension surrounding the IFHP. On interviewing healthcare professionals in Hamilton, Canada, one study found that many practitioners were reluctant to take patients covered by the IFHP due to the increased paperwork and lack of knowledge surrounding the program (13). Another study examined the extent of the lack of knowledge that healthcare practitioners in Montreal,

Canada, had about refugee health. Results of the survey they conducted shows that 39% of the practitioners did not get a single answer (out of the three multi-part questions) correct (12). As such, these alarming statistics bring to light that the first problem that must be tackled to better refugee healthcare is providing healthcare workers with accurate and accessible information about the IFHP.

3. Government Officials and Policy Makers

Government officials have one of the largest influences in the decision-making process on the delivery and accessibility of healthcare. Many policy makers were the subject of scrutiny by healthcare workers and CSOs after the 2012 IFHP cuts were made. However, even after the reforms in 2014, policy makers have constructed an overly complex system and have rolled out substandard implementation procedures. Moreover, there has been an absence of accountability in policy implementation, and more specifically in information circulation surrounding the policy, as indicated by the poor uptake of knowledge about the IFHP system by healthcare workers (12, 13).

4. Civil Society Organizations (CSOs)

CSOs dedicated to refugees, such as the CCR, provide services to refugees through settlement aid, and activities to welcome newcomer families into the community. The organizations also advocate for refugee rights, and promote refugee participation in government decision-making (13). While the direct influence of CSOs in policy making vary widely, these organizations are extremely valuable for increasing awareness through social media and media relations that can get the attention of more influential stakeholders to take action (14).

Most recommendations thus far for IFHP implementation are geared towards physicians or government officials (10, 15) or are long-term policy-level recommendations (5) at the population level. The lack of awareness that healthcare workers, organizations, and government officials have about the IFHP in terms of their legal and ethical duties is astounding (12, 16). Effective dissemination of information and awareness-raising is needed before any systemic changes can take place. These actions necessitate the inclusion of other groups such as civil society organizations. These organizations are involved in the settlement, sponsorship and protection of refugees and immigrants and are committed to the rights and protection of refugees and other vulnerable migrants in Canada and around the world. Our article consolidates and expands on previously made recommendations and outlines novel suggestions aimed at key stakeholders involved in the provision of healthcare access for refugees.

Barriers in Healthcare for Refugees

The current Canadian healthcare system is built on the

principle that the need for healthcare, not the ability to pay for it, dictates access to healthcare services. At a policy level, the IFHP is aligned with this principle. The IFHP aims to provide health services free of charge for all refugees. However, in practice, IFHP implementation has been far from equitable. Refugees already face various barriers in healthcare that are further exacerbated by the confusions surrounding the IFHP. We have identified three main themes in the hurdles that refugees must overcome in order to access healthcare: communication, administrative, and socio-political barriers.

Communication Barriers

Refugees face an information deficit around the topic of health insurance and coverage when they attempt to access the healthcare services available to them. There has not been any significant communication directed to the providers, refugee lawyers, refugee-serving organizations, or the refugees themselves, even after the changes from 2012 to 2016 (17). There have been no additional efforts or guidelines implemented by the government to disseminate this vital information, even though the IFHP directly impacts healthcare access to refugees.

Although refugees may successfully sign up for the IFHP on landing, many refugees do not know how to provide proper documentation for the use of this program and struggle to find willing healthcare providers that are registered to MBC. Additionally, there has been little to no funding for interpretation services for refugees. A scarcity of access to same-language workers that are the first point of contact for refugees entering into Canada, like Canadian Border Services Agents and settlement workers has left many refugees with unanswered questions and unmet needs (9).

Administrative Barriers

Gaining insurance with the IFHP is not automatic upon landing in Canada. In addition to many post-migratory stress factors including finances, housing, and loss of support networks, individuals must also apply for this coverage by the IFHP. They must complete the requisite forms correctly and have legal documents sent to the Immigration, Refugees and Citizenship Canada (IRCC) office either online or through mail, all while facing language barriers in an unfamiliar country (9). Many refugees have reported being turned away by community health clinics because they simply do not meet enrollment requirements such as adequate proof of identifying documents or evidence that the individuals reside within the clinic’s prescribed geographical radar (15).

After a waiting period of three months since landing, refugees with the exception of refugee-claimants are eligible for provincial insurance – a process that echoes similar administrative barriers. In light of the COVID-19 pandemic,

provincial governments temporarily waived the waiting period, allowing for uninsured refugees to receive testing and treatment for the pandemic (9). However, it is unclear if this change in policy will be retained for urgent care even after the pandemic.

Social-Political Barriers

Even with multiculturalism at the center of the Canadian identity, an othering discourse has persisted in contemporary society. The perception of refugees as foreign or unwanted in Canada has resulted in a refusal of full provincial coverage upon arrival and widening the gaps between them and the Canadian population. With the media portraying bogus refugees as line jumpers to gain entry into Canada, programs such as the IFHP have been poorly implemented and have been fraught with budget cuts, overly complex administrative processes, and very little information dissemination (18).

Furthermore, the denial of healthcare services to refugee patients coupled with a lack of mandatory cultural training for healthcare professionals has been detrimental to the quality of life of refugees. These factors combined explain how providers refuse new refugee clients given the increased paperwork and new reimbursement processes (6).

Recommendations for Stakeholders

Government Officials

1. Government officials must reduce the complexity of the IFHP.

Every aspect of the IFHP from eligibility, coverage, service provision to reimbursements are plagued with confusion from both patients and professionals (6). Government officials must streamline IHFP claims processes for patients, CSOs, organizations, and professionals. Some steps may include every refugee or refugee claimant automatically being eligible for the IFHP (instead of needing them to first apply to the IRCC) and creating one piece of documentation that refugees can use to prove their identity, residency status, as well as their insurance coverage. While it is unlikely that they can use a single application to apply for both IFHP (federal) and provincial insurance, both applications must be provided at the same time with clear instructions on submission steps.

Ultimately, reducing the complexity of the IFHP is only a band-aid solution to combat the confusion and barriers faced by refugees to access healthcare. In the long term, government officials must aim to provide refugees with provincial health insurance cards on landing in Canada. This would eliminate the need for having providers sign up with MBC, bill a separate company, and thus increase access to physicians for refugees. The provincial governments may then bill the federal government for the services provided, which would

reduce the complexity in administrative processes.

2. Governmental bodies must effectively disseminate information for refugees.

Professionals in the government should help refugees and refugee claimants integrate into the new country by effectively disseminating information. This could be achieved through improving their websites. Remodeling current websites to increase clarity, making in-built translations of that website in several common languages, and having a chat function or helpline that can assist clients one-to-one get answers to queries that otherwise would be harder to access.

Governmental bodies must use traditional social media platforms as they have been shown to be an effective tool to drive awareness and educate patients who may not have high health literacy (19, 20). As many refugees and refugee claimants themselves often have low levels of health literacy (9), multilingual campaigns with posters, videos, and information sheets on social networking sites or forums that refugees use will greatly help disseminate important information such as locations for support, resources for filling out applications, and answering frequently asked questions.

3. Governmental bodies must effectively disseminate information for healthcare providers.

Similarly, directives to healthcare providers must be simple and easy to understand. It is the responsibility of the government to ensure that information about their social programs are being dispersed to physicians. Currently, the IFHP handbook for professionals is twenty-five pages long and details eligibility of clients, reimbursement processes, auditing information, and terms and conditions for different specialties including primary healthcare, and dental and vision coverage. Even with this comprehensive handbook, literature has shown that the knowledge of refugee health in Canadian healthcare workers is alarmingly low (12, 13). The key points of the handbook must be summarized into key points in deliverables, which must then be distributed to primary care physicians (such as family health teams or walk-in clinics). Additionally, workshops regarding the same must also be made available in primary care physician circles. This can be achieved through a collaboration between the IRCC, provincial governments, and the MBC to increase knowledge provision in healthcare providers.

4. Government officials must adopt a “Health in all Policies” approach.

While the above recommendations help tackle specific issues faced by refugees in Canada, the federal government must adopt a cohesive and synergistic approach for refugee healthcare. The “Health in all Policies” (HiAP) approach carefully considers all health and social implications of any

policy and aims to minimize harm to the population (21). Downstream consequences, both direct and unintended, are carefully examined and concerns are addressed before any policy is passed. One crucial aspect of the HiAP is the attention to root causes of poor health, which include poor physical infrastructure (e.g. hospitals, centers for refugee information, etc.) and accessibility to services and supports (21). Adopting a HiAP framework during the genesis of refugee health policy would have ensured that proper infrastructure and funds were in place to reduce administrative, communication, and socio-political barriers. This approach, for example, would recognize that increased migration and cultural diversity can lead to reduced access to care and poor health outcomes due to cultural and language barriers. Therefore, it would have prompted potential solutions to ensure increased funding of community translators and culture-specific system navigators and the passing of anti-discriminatory legislation preemptively (21). There are large gaps between providing healthcare for refugees on paper and the reality of it (15). Therefore, officials must adopt the HiAP framework to bridge this gap in future policy making.

5. Government officials must increase funds for refugee health.

Lastly, government officials must increase funding for the IFHP to accomplish the above recommendations about effective policy implementation, information dissemination about the IFHP, and interpretive services. This must also include having public grants for CSOs that are often underfunded and rely on private donations in order to help this vulnerable population.

Physicians and Practicing Professionals

1. Professionals must educate themselves and their peers.

Professionals must keep informed on the policies regarding IFHP by engaging with educational sessions provided by governmental bodies within their professional communities on the topics of cultural competency, refugee health, and the IFHP. As knowledge sharing was one of the primary reasons physicians cited for using social media (22, 23), they must use their platforms to then share information about training workshops as well as about resources about refugee health produced by CSOs, MBC and other organizations.

Additionally, it is the responsibility of educational institutions in Canada to provide their graduates with knowledge of the healthcare policies and programs in place, including the IFHP. Currently, there is no literature describing the level of knowledge of refugee health in professional educational programs. The benefit of educating budding professionals before the completion of their training is two-fold. Many of these trainees work at various hospitals, clinics, and counseling sites during their training years, which could inform more practitioners about registering as MBC providers. It

would also be beneficial to have future professionals already familiar with the challenges faced by refugees so that they are able to provide informed and culturally competent care.

2. Professionals must hold each other accountable.

They must ensure that their peers in the hospitals, clinics, and pharmacies they work at are registered under MBC. In addition to using social media, they must use professional channels such as the hospital administration and conferences to urge other practitioners to become MBC providers themselves. Health professionals must further put into place measures of accountability so that refusing patients based on residency or insurance status has negative consequences (such as financial deductions or legal consequences) that hold them accountable.

3. Professionals must try to provide culturally sensitive care.

Many refugees have described how culturally insensitive interactions with the healthcare system deter them from seeking out care in the future, which has further led to poor health outcomes (9). Cultural competency training has shown to have positive impacts on patient satisfaction, health outcomes, and physician knowledge (24-26). This training should be mandatory and must equip practitioners with strategies to provide care for people from different cultures with limited knowledge of English or French, reflection spaces to detect one's own biases, and first-hand stories from refugees. In addition to attending mandatory training, professionals must ensure that they are able to provide some level of same-language care. A systematic review on the impact of language interpreters in a healthcare setting showed that the presence of interpretive services or a bilingual healthcare professional positively affected patients' satisfaction, quality of care, and health outcomes (27). Professionals who serve a large number of refugees must ensure that they or members of their staff can speak languages spoken predominantly by refugee populations or have access to interpreters. With the scarcity in interpretive services in Canada, it is of utmost importance for physicians and all others involved in the delivery of care to be comfortable working with culture brokers, patients' families, and CSOs that can aid in culturally-appropriate care (28). In the long term, professionals must advocate for access to interpreters available in the healthcare system.

4. Professionals must advocate for the improvement of the IFHP.

Physicians can advocate for individual patients by ensuring that all staff are equipped with the competencies to deal with refugees. They must also advocate on an institutional level to ensure that all practitioners in their organizations are MBC registered providers and at the regional level by calling for more funding for refugee health, for example, for more

interpretive services. To make changes at the policy level, they must also communicate with government officials and authorities through one-on-one discussions, letter writing, social media campaigns, and legal procedures - all of which were demonstrated when protesting the 2012 cuts to the IFHP.

CSOs

1. CSOs must hold cultural competence training workshops.

Many studies have shown that cultural competence training increases professionals' knowledge, patient satisfaction, and mutual understanding between patients and professionals (21 - 23). Cultural competency training specific to refugee health would be very beneficial to make professionals cognizant of struggles faced by refugees in navigating various barriers to healthcare. Providing these workshops during medical school would be especially impactful. This would aid them in providing more sensitive care to their patients and prevent their patients from feeling othered during their interactions with the system. While CSOs have ties with the communities that make them well placed to achieve this, they are often underfunded. For example, most of the funding for the CCR is through private donations and membership fees (29). Public grants organized by the government and professional institutions would aid in sustaining these organizations.

2. CSOs must connect with local communities.

CSOs must form branches of outreach programs to their local communities, especially in areas with high immigrant and refugee densities. With the paucity of interpreters, CSOs also must try to provide same-language administrative support for incoming refugees to combat the communication barriers they face. This may also provide opportunities for resettled refugees and immigrants to work for the CSOs in helping other newcomers to Canada and allow them to form connections to prevent the social isolation that many refugees face. Once again, it is imperative that there are public grants for these refugee serving organizations.

3. CSOs must advocate for the improvement of the IFHP.

CSOs must use social media campaigns, media relations, and governmental ties to call for the improvement of the IFHP. They must push for the release of easily accessible and informative resources from MBC, simplification of the administrative process surrounding application, and promotion of the IFHP to hospitals and local community partners. Finally, they must advocate for the restoration of services provided before the 2012 cuts (30, 31).

Discussion

Our study has contributed two important items to the

discussion of the IHFP: common barriers as well as pointed recommendations for stakeholders of the IHFP. Refugees face communication barriers due to a lack of multilingual resources, administrative barriers due to complex application processes, and socio-political barriers primarily caused by an othering narrative.

We have also attempted to make concrete recommendations based on previous literature to multiple stakeholders to address these barriers. Compared to previous studies that have made recommendations to combat the inefficiency of the IFHP by focusing mainly on physicians or governmental bodies (5, 10, 15), we have attempted to consolidate recommendations for multiple stakeholders, including CSOs.

Limitations

Although our article provides recommendations and has reviewed the literature, there has been no measure of effectiveness of programs that provide refugee health training related to the IHFP to healthcare professionals. This article has also focused primarily to address the most common barriers to healthcare access. As such, more research is needed into other aspects of refugee experiences such as financial stability, impact of the COVID-19 pandemic, and consequences of surge in refugee intake (such as the 2021 Afghanistan refugee crisis (32)) to gain a more holistic view of the population. Lastly, the phrase refugees was used as a homogenous term even though the population is anything but homogenous. It is imperative that future research differentiates between different populations of refugees so that each population's voice and unmet needs are represented and explored.

Conclusion

The IFHP provides crucial healthcare insurance to the thousands of refugees in Canada each year. However, research has demonstrated that the gap between coverage and the actual access to healthcare is extremely wide. Healthcare professionals, CSOs, and government officials must work in tandem to provide a more simplified process that improves refugee health and integration. CSOs must target local communities and raise awareness to tackle misinformation and dismantle the othering narrative that stigmatizes refugees. Healthcare professionals must engage in knowledge uptake and have accountability measures in place so that individuals are provided with care regardless of their residency status. Finally, government officials must bridge the gap between policy writing and policy implementation by simplifying the process and adopting a HiAP approach when making decisions about refugees. Canada and its healthcare system were built on the values of equity and embracing multiculturalism. For these values to expand beyond performative, the political narratives and

biases deeply embedded in refugee health policies must be reexamined and excised.

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