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## Reducing Health Services for Refugees Through Reforms to the Interim Federal Health Program

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## Abstract

Since 1957 the Interim Federal Health Program (IFHP) has provided temporary health care coverage to refugees and refugee claimants, but in 2012 the Conservative government reformed the IFHP, reducing, or eliminating access to health services for these groups. The government framed the changes around fairness and safety, stating that it would save taxpayers \$100 million over five years, reduce incentive for migrants with unfounded refugee claims from coming to Canada, protect public health and safety, and defend the integrity of the immigration system. With a Conservative majority, the reform was easily implemented despite a lack of evidence supporting these claims. In 2014, the Federal Court rejected the government's notion of fairness and safety, ruling that the cuts were cruel and unusual treatment of an already vulnerable population. The government appealed this ruling but, in 2016, the Liberals took power and restored funding to the IFHP to pre-2012 levels. Ad hoc evaluations predicted inequitable and adverse impacts on refugees, negative impacts on health, and increased costs to refugees, provincial governments, and health providers. Overall the threats and weaknesses of this reform clearly outweighed the few and unconvincing opportunities and strengths of the program, leading to its demise.

*Depuis 1957, le Programme fédéral de santé intérimaire (PFSI) offre une protection en matière de soins de santé temporaires aux réfugiés et aux demandeurs d'asile. Néanmoins en 2012, le gouvernement conservateur a révisé le PFSI afin de réduire ou éliminer l'accès aux services de santé pour ces groupes. Le gouvernement conservateur a présenté cette réforme au nom des principes d'équité et de sécurité, en affirmant qu'elle ferait économiser 100 millions de dollars en cinq ans, tout en préservant l'intégrité du système d'immigration. Il soutenait que cette réforme budgétaire découragerait les fausses demandes d'asile et protégerait la sécurité nationale et la santé publique. À l'époque où le gouvernement conservateur avait la majorité, la réforme a rapidement été mise en place, malgré un manque de preuves crédibles des affirmations. En 2014, la Cour fédérale a rejeté la notion de d'équité et de sécurité du gouvernement et jugé que ces coupes budgétaires pouvaient être considérées comme une peine cruelle et inusitée à l'encontre d'une population déjà vulnérable. Le gouvernement conservateur a ensuite fait appel de cette décision de la Cour fédérale, mais les Libéraux, arrivés au pouvoir en 2016, ont finalement pu remettre en place le financement du PFSI. Des évaluations ad hoc de cette réforme ont prédit des impacts inéquitables et négatifs, non seulement sur les réfugiés (conséquences négatives sur la santé et augmentations des coûts de la vie), mais aussi sur les gouvernements provinciaux et les fournisseurs de santé. Finalement, les menaces et faiblesses clairement identifiées de cette réforme l'emportaient sur les possibilités et avantages peu convaincants, menant ainsi à sa disparition.*

### Key Messages

- In 2012, the Conservative government reformed the Interim Federal Health Program, reducing or eliminating health services to many refugees and refugee claimants.
- The government framed the reform around a specific notion of fairness and safety, which health professionals and advocacy groups rejected.
- There was little evidence that this reform would save money and increase public health and safety.
- The Federal Court deemed the cuts “cruel and unusual treatment,” and the funding was restored to the IFHP by the subsequent Liberal government.

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### Messages-clés

- *En 2012 le gouvernement conservateur a modifié le Programme fédéral de santé intérimaire afin de réduire l'accès aux services de santé d'un grand nombre de réfugiés et de demandeurs d'asile.*
- *Le gouvernement a basé les révisions sur une définition particulière de l'équité et de la sécurité que des professionnels de la santé et des groupes de plaidoyer avaient rejetés.*
- *Peu de preuves crédibles que cette réforme ferait économiser de l'argent et protégerait la sécurité nationale et la santé publique avaient été présentées.*
- *La Cour fédérale a jugé que ces coupes budgétaires étaient considérées comme une punition « cruelle et inusitée » et le financement du PFSI a été remis en place par les Libéraux en 2016.*

## 1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In April 2012, changes to the Interim Federal Health Program (IFHP), which became effective on 30 June 2012, were announced by Jason Kenny, the Conservative Minister of Citizenship, Immigration and Multiculturalism (Barnes 2013). Before the reform, the IFHP provided temporary health care coverage to eligible refugees, refugee claimants and others who did not qualify for provincial or territorial health care plans. In some cases, IFHP offered supplemental services such as prescription drugs, dental, and vision care. The cost of the IFHP was \$86.4 million in the 2010-2011 fiscal year (GOC 2012).

Under the 2012 reform, access to health services for refugees was reduced, or in some cases, eliminated (Barnes 2013). This was notable in the context of the Designated Country of Origin (DCO) list implemented in 2010, which features countries deemed “safe” and not likely to produce “legitimate” refugees. Refugees from non-DCOs became eligible for health care coverage only if it was deemed urgent or essential, and they no longer had access to preventative or supplemental benefits (e.g., medications). Rejected refugees and those from DCOs only received care to prevent or treat a disease posing a risk to public health or a condition of public safety concern (Barnes 2013). To illustrate the impact of the cuts, medications such as insulin or cardiac drugs would no longer be covered for impoverished refugee claimants from war-torn countries such as Iraq (*CDRC v Att Gen.* 2014).

The key driver of the reform was the government’s perception of fairness to Canadian taxpayers. Specifically, the Minister stated that it was not fair for taxpayers to pay for the health care of individuals who had never contributed to the system (and who may never contribute if their refugee claims are rejected). The Minister also asserted that “illegitimate” refugees were making bogus claims to Canada in order to benefit from the publicly funded IFHP (GOC 2012). He claimed that the reforms would protect the health and safety of Canadians, however health professionals and advocacy groups rejected the government’s conception of fairness and assertion of safety, arguing that the cuts were inhumane and a public health disaster (Belluz 2012). The reform ultimately failed after a Federal Court sided with those who opposed the changes, ruling that the changes constituted cruel and unusual treatment of a vulnerable population (*CDRC v Att Gen.* 2014). The IFHP was reinstated by the subsequent Liberal government (*CBC News* 2016).

## 2 HISTORY AND CONTEXT

**1957:** IFHP established by the federal government through Order-in-Council PC 157-11/848

**2010:** [Conservative] government introduced the *Balanced Refugee Reform Act, 2010* which received Royal Assent later that year and established DCOs

**2012:** [Conservative] government introduced *Protecting Canada’s Immigration System*

*Act* which received Royal Assent on 28 June

**2012:** [Conservative] government reformed the IFHP; changes took effect on 30 June

**2012:** Québec institutes its own coverage for all refugees

**2013:** Canadian Doctors for Refugee Care and the Canadian Association of Refugee Lawyers take the government to Federal Court (*Voices* 2014)

**2014:** Ontario creates Ontario Temporary Health Program (OTHP) for refugees on 1 January

**2014:** Federal Court judgement on 4 July declared the cuts to IFHP unlawful and unconstitutional

**2014:** The government appeals the ruling on 1 October

**2016:** [Liberal] government fully restores all refugee health care benefits to pre-2012 levels on 1 April

### 3 GOALS OF THE REFORM

#### 3.1 Stated

Reduce health care costs by \$100 million over five years to ensure fairness for Canadian taxpayers, remove incentive for people to file unfounded refugee claims in Canada, protect public health and safety, and defend the integrity of the immigration system (GOC 2012).

#### 3.2 Implicit

Reduce the role of the federal government as a part of a broader set of austerity measures and display fiscal responsibility (Harris and Zuberi 2015).

### 4 FACTORS THAT INFLUENCED HOW AND WHY

#### 4.1 The issue came onto the government's agenda

While there was no triggering event, the political climate was favourable to make reforms to the IFHP. Still recovering from the 2008 financial crisis, there was an appetite for austerity in many countries, including Canada. Coupled with a chronically strained health care system, cuts to refugee health care were framed to be economically sound and morally justified by using a specific notion of fairness (GOC 2012).

The cuts were quietly introduced into the 2012 March budget and followed by a public announcement the next month (*Voices* 2014). From the government's view, the reform was poised for success because it was easy to implement—funds for refugee health care were simply removed from the budget and the cuts did not directly affect the majority of Canadians, the electorate.

On top of this, the ruling Conservative government held a majority in Parliament, meaning they could pass legislation without garnering any opposition party support. Despite the opportune circumstances, advocacy groups that were opposed to the reform mobilized public awareness to the potential impacts of the cuts and challenged the government's assertion of fairness. They argued that targeting some of the most vulnerable people in Canada is decidedly unfair, that refugees do not receive any more support than those with limited means covered by social assistance programs in most provinces, that the government created a two-tiered system whereby individuals receive vastly different treatment solely based on their country of origin, and that the reform introduced systemic barriers to health care (Arya, McMurray and Rashid 2012; *Voices* 2014).

## 4.2 The final decision was made or not made

Refugees are a small and already highly vulnerable population that has little power or voice, which may explain why the Conservative government could easily advance the reform. However, due to activism by health care providers, editorials in national newspapers and letters from medical associations, refugees sponsored by the government and certain privately sponsored refugees were excluded from the cutbacks (Arya, McMurray and Rashid 2012).

The changes were framed by the government's perception of fairness. Focusing on fairness rather than effectiveness reduced the need for substantive evidence to support the Minister's claims. Indeed, in Europe, policies that restricted access to health care had limited success in deterring undesirable migrants (Arya, McMurray and Rashid 2012). Furthermore, there were no economic analyses that substantiated the \$100 million projected savings over five years (*Ibid.*). One study in Oregon could have bolstered the Minister's claims, as it found that the insured spent an average of 25 percent more on health care than the uninsured (Belluz 2012). However, the annual cost of coverage per refugee under the IFHP was likely between \$562 and \$660, compared to \$6,141 per capital spent on health and social services for Canadians (Arya, McMurray and Rashid 2012). Despite the lack of evidence of the policy's potential effectiveness, the majority Conservative government was able to implement the changes to the IFHP.

# 5 HOW THE REFORM FAILED

## 5.1 Policy instruments

The government presented the reform to the IFHP as a part of a broader modification of refugee policy. *The Balanced Refugee Reform Act, 2010* (S.C. 2010, c.8) allowed the Minister to identify DCOs that do not normally produce refugees and that are thought to respect human rights and offer state protection (Barnes 2013). They are deemed likely to be "safe" if they have an independent judicial system, recognize basic demographic rights

and freedoms, and have civil society organizations (*Ibid.*). This act was widely criticized for placing too much control in the hands of the Minister, for not recognizing that some people are unsafe even within “safe” countries, and for deeming some refugees as “deserving” and others as “undeserving” (*Ibid.*).

Bill C-31, *the Protecting Canada’s Immigration System Act*, gave the Minister even more and unprecedented increases in power for adjudicating refugee claims. In the bill, the process for designating certain countries as “safe” from the 2010 Act eliminated an expert, independent advisory body that included human rights experts (Bill C-31, 2012 c.17). The DCOs were a centrepiece of the IFHP reform, which came into effect two days after Bill-C31 received Royal Assent on 28 June 2012.

## 5.2 Implementation plan

There was no prior consultation with non-governmental stakeholders and, it appears, no prior consultation with the provincial governments (French 2012). The reform to the IFHP came into effect on 30 June 2012 and coverage simply stopped for many refugees, depending on their status. Confusion in the succeeding two months among refugees and providers suggests that the reform was not well implemented. Eligible refugees requiring urgent care were being turned away from emergency departments (Arya, McMurray and Rashid 2012), and there was “a maze of procedures, forms and technicalities” that made the health care system under the reform difficult to navigate (*Voices* 2014, para. 15).

## 5.3 Communication plan

There was little communication about the reform, other than a Government of Canada press release, and a petition launched by the Minister himself in support of the plan. The petition reiterates that “smuggled migrants and bogus asylum claimants should [not] be getting better health care benefits than Canadian seniors and taxpayers” (*National Post* 2012). Since the reforms were entirely within the Minister’s powers, this petition was a communication strategy to draw attention to the changes and gather support among Canadians.

## 5.4 Failure

Promptly after the federal cuts, to reduce the gap in health coverage for refugee claimants, Québec instituted its own Public Safety Health Care coverage for refugees who no longer received the IFHP coverage. On 1 January 2014, Ontario created the Ontario Temporary Health Program (OTHP) for refugees in order to meet its humanitarian obligations and to reduce unnecessary emergency room visits and stress on health care providers (*CBC News* 2016; *CDRC v Att Gen.* 2014). This drew accusations from Ottawa that Ontario was intruding on federal responsibility, and Immigration Minister Chris Alexander called the decision irresponsible, making Canada and Ontario a “magnet for bogus asylum seekers”

(Payne 2014). Ontario maintained that if it is not prohibited by law and the expenditure of funds was approved by the legislature, the program was legitimate (*Ibid.*).

In tandem with growing provincial action, Canadian Doctors for Refugee Care and the Canadian Association of Refugee Lawyers took the government to Federal Court, asserting that the IFHP reform violated sections of the Canadian Charter of Rights and Freedoms. On 4 July 2014, using pointed language, the Federal Court rejected the government’s assertions of fairness and public safety, and deemed the IFHP reform unlawful and unconstitutional. The basis for the judgement was that the reform “shocks the conscience and outrages our standards of decency” and the “treatment is indeed ‘cruel and unusual’ ” (*CDRC v Att Gen.* 2014, p. 8).

The Conservative government appealed the ruling and introduced a temporary measure to comply with the Court’s decision. The hearing was scheduled to start on 26 October 2015. However, the newly elected Liberal government withdrew the appeal, and on 18 February 2016, announced that it would restore the IFHP to the same levels of coverage that existed prior to the 2012 cuts, complying fully with the original Federal Court decision (*CBC News* 2016).

## 6 EVALUATION

No planned evaluations were outlined in government documents, but there were several *ad hoc* evaluations. The Wellesley Institute analyzed the potential impact of the program using a Health Equity Impact Assessment framework. Its analysis predicted inequitable impacts on some groups (e.g., those from DCO countries, women, and children) and adverse impacts on all refugees, as accessing even basic health care would be increasingly difficult. Additionally, there would be increased numbers of refugees presenting in the emergency room, adding to wait times, and that there would be an increase in some chronic conditions among refugees (Barnes 2013).

A one-year retrospective chart review study examining emergency room visits at the Hospital for Sick Children in Toronto six months before and six months following the IFHP cuts determined that the hospital was unable to obtain federal health coverage for the vast majority of refugee claimant children registered under the IFHP, and that the costs were absorbed by the hospital (Evans *et al.* 2014). The question of how the reforms impacted Canadian politics is as yet unstudied.

## 7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> <li>● Projected \$100 million savings for the federal government</li> <li>● From the Conservative government’s perspective, the cuts were fair to Canadian taxpayers and the immigration system</li> </ul>	<ul style="list-style-type: none"> <li>● Confusion among refugees and providers about what health care services were covered for whom (Arya, McMurray and Rashid 2012)</li> <li>● Violations of several sections of the Charter of Rights and Freedoms (e.g., cruel and unusual treatment)</li> <li>● Denial of basic health care to an already vulnerable population is inequitable and inhumane</li> <li>● Government decision was not evidence based</li> <li>● Health professionals strongly opposed the cuts</li> </ul>
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>● Discourage unfounded refugee claims</li> <li>● Provinces could step in to cover refugee’s health care (e.g., Ontario created a temporary health program to meet its “humanitarian obligations”) (<i>CBC News</i> 2016)</li> <li>● Possible political gains for the Conservative Party</li> </ul>	<ul style="list-style-type: none"> <li>● Increase in costs for provincial governments, refugees and health care providers (Arya, McMurray and Rashid 2012)</li> <li>● Increase in illness and conditions among refugees due to, for example, unaddressed medical needs (Barnes 2013)</li> <li>● Increase in health disparities</li> <li>● Increase in emergency room (ER) wait times, with increased numbers of refugees presenting in ERs (Barnes 2013)</li> <li>● Increases in tension toward refugees and immigrants due to the negative political rhetoric</li> </ul>

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