

# **CFMS Position Statement on Refugees and Asylum Seekers**

## **Problem History**

### **Background of the Problem**

The United Nations High Commission on Human Rights defines a refugee as someone who, “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country”. The *1951 Convention Relating to the Status of Refugees* and the *1967 Protocol Relating to Refugees* (Refugee Convention and Protocol) are the global legal instruments that provide binding standards for protection and care of refugees and asylum seekers<sup>1</sup>; Canada acceded to these agreements in 1969. The Refugee Convention states “refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to the highest standards of physical and mental health.”

To ensure this right to health for refugees and asylum seekers, in 1957 Canada developed the Interim Federal Health Program (IFHP), intended to provide temporary health insurance coverage to refugees, refugee claimants<sup>2</sup> and protected persons who are otherwise not covered by provincial or territorial health insurance plans. Under the IFHP, supplemental health services including immunizations, preventative medical care, essential prescription medications, vision tests, non-emergency dental care, and prenatal/obstetrical care were provided at a similar level to Canadian citizens who qualified for social assistance.

### **Current Status**

In the summer of 2012, changes were made to Canada’s immigration system in response to the perception that Canada had been receiving and accepting a disproportionate number of unfounded refugee claimants. The legislative changes found in the *Protecting Canada’s Immigration System Act* (Bill C-31) allows the federal Minister of Immigration to designate certain countries as Designated Countries of Origin (DCO), or those countries that should be “safe” and therefore not produce refugees. While under the new system all refugee claimants have a much accelerated timeline (60 days) for making their claim, those from DCOs have only 30-45 days in which to prepare their claim. C-31 also allows for refugee claimants deemed “irregular arrivals” to be subject to detention, with review every 6 months. According to CIC, the goal of C-31 is that “genuine refugees fleeing persecution will receive protection more

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<sup>1</sup> The terms refugee and asylum seeker are not interchangeable. According to the UNHCR: “The terms asylum-seeker and refugee are often confused: an asylum-seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated.”

<sup>2</sup> An asylum seeker whose claim is being evaluated by Canada’s Immigration and Refugee Board is termed a “refugee claimant”.

quickly. At the same time, bogus asylum claimants and those who abuse our generous system at great expense to taxpayers, will be removed much faster.”

In addition to C-31, changes were made to the IFHP such that all refugees and refugee claimants other than government-assisted refugees (GARs) have lost supplemental and preventive care, with their coverage limited to that of an “urgent and essential” nature. Furthermore, DCO refugee claimants have lost all health care coverage whatsoever, unless their condition is a threat to public health or safety. The rationale for this change was ostensibly about equity and cost saving, cutting “benefits for protected persons and refugee claimants that are more generous than what they are entitled to themselves” while saving \$20 million each year.

### **Statement of the Problem**

The Canadian Federation of Medical Students is concerned that the aforementioned changes to Canada’s refugee system and IFHP will:

- a. contravene Canada’s obligations under international law
- b. lead to increased, not decreased, health care costs
- c. pose serious ethical problems for health care providers and institutions

#### *Contravention of Canada’s Obligations under International Law*

Denying refugees access to basic health care is inconsistent with Canada's long-standing commitment to international agreements that define and protect the rights of vulnerable persons. As noted in Amnesty International's 2013 Human Rights Agenda, Canada joined the International Covenant on Economic, Social, and Cultural Rights through accession in 1975. According to Article 12, Section 2 of this Covenant, Canada has committed to "... (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness". In addition, the United Nations High Commissioner for Refugees (UNHCR) indicates that "The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population...". Refusing to fund health services or medications for all but a subset of refugees is clearly not in keeping with the principles set forth by the Covenant or the UNHCR.

The UNHCR’s definition of a refugee emphasizes that dangerous personal circumstances, rather than country of origin, determine whether someone is a refugee. However, refugee claimants from Designated Countries of Origin (DCO) have less access to health care than refugee claimants from other nations. This disparity is not congruent with Article 3 in the 1951 Refugee Convention, which advises "The Contracting States shall apply the provisions of this Convention to refugees without discrimination as to race, religion or country of origin".

#### *Increased Health Care Costs*

By restricting many individuals’ access to urgent and essential services, and others’ access to all but emergency services, IFHP changes will lead to the undertreatment of chronic

health conditions such as diabetes and coronary artery disease. It is questionable whether this reduction in care, while leading to cost-cutting in the federal budget, will actually save money overall. Emergencies tend to be treated in hospitals and Emergency Departments at a much higher cost than the care required to prevent them. In terms of diseases that will still be covered as “public health risks”, it’s important to note that it is best for these diseases to be found early, in the primary and preventive health visits that the IFHP changes have ended. Waiting until a refugee claimant presents to an Emergency Department with the late stages of a communicable illness such as tuberculosis greatly increases the chance that others have already been exposed, and further dilutes the potential economic savings from no longer covering primary or preventive care.

### *Ethical Issues*

The cuts to the IFHP and Bill C31 have introduced ethical quandaries into the therapeutic relationships between individual health professionals and their refugee and asylum seeker patients. Physicians now need to decide how much care they provide to refugees without compensation in the context of their responsibilities to other patients and limited public resources.<sup>1</sup> Similarly, if refugees who only qualify for public health risk coverage present with an emergent condition, the CMA code of ethics stipulates that physicians have a duty to provide care, even though there is no compensation structure in place<sup>2</sup>. Thus, individual healthcare providers in these situations are left with no clear guidelines for how to proceed without breaching their code of ethics or providing uncompensated care.

With the guidelines set forth by the IFHP, health care institutions are also left to answer several difficult questions. Denying health care to a person immediately seeking it in order to save resources for future patients is ethically controversial; it forces health care providers to choose between compassion and fiscal responsibility. Since health care organizations will fear treating patients without coverage at a financial risk to themselves, it is likely that most administrations will be forced to take a conservative approach in deciding what constitutes a life-threatening medical problem. This moral conflict is further exacerbated by the vague definitions that the IFHP cuts leave in their wake, as the boundary of what constitutes an urgent or life-threatening condition is often arbitrary.

Without clear definitions and guidelines in place, health care providers and institutions may be forced to make ethically questionable decisions. In effect, these policy changes use health care as a tool of immigration policy and make health providers and institutions into de facto immigration officials.

### **Recommendations**

The Canadian Federation of Medical Students recommends that:

1. The changes to the Interim Federal Health Program be reversed, restoring full health coverage to all refugees and asylum seekers, along with supplemental coverage for those who qualify for it

2. The changes made to Canada's immigration policy that contravene Canada's obligations to international refugee law be reversed including
  - a. That refugee claimants' cases be evaluated on the merits of their claims, and not on their country of origin
  - b. The cessation of arbitrary detention of refugee claimants based on mode of arrival
3. That, while improvements in Canada's refugee status determination process to increase its efficiency and cost-effectiveness are laudable goals, these goals should not come at the expense of the human rights of refugees and asylum seekers.
4. That, in the current policy situation, clear guidelines for health providers and institutions be developed by multiple stakeholders, including health provider organizations, governmental bodies, and community organizations to ensure the highest level of care, and the highest ethical standard, currently possible.

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