

PROTECTING REFUGEES' HEALTH: HOW IS THE REINSTATED INTERIM FEDERAL HEALTH PROGRAM WORKING?

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RESEARCH REPORT

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by

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Executive Summary

Publicly-funded health care for refugees and refugee claimants in Canada is provided through the Interim Federal Health Program (IFHP). After experiencing extensive cuts in June 2012, IFHP was restored in April 2016. There is presently limited information on how the reinstated IFHP is meeting its purported objective of, among others, protecting refugees' and refugee claimants' health and safety. As a step toward filling this gap in the literature, our research team conducted a pilot study in 2017 with refugee-serving practitioners in the City of Ottawa. We found the current IFHP, despite significant improvements from the years of cuts, falls short in several aspects. A legacy of confusion about the IFHP persisted among service providers, and the processes for service providers to register in and to seek reimbursement from the IFHP was seen as burdensome. Anecdotal evidence indicated that these ongoing problems were hindering IFHP beneficiaries' timely access to quality health care.

Motivated by findings from the pilot study, further research was conducted between July 1, 2018 and July 31, 2020 to better gauge IFHP's current performance. This study interviewed refugees and refugee claimants in addition to refugee-serving practitioners. And among service providers interviewed, efforts were made to recruit those from professions that were left out in the pilot, including dentists, optometrists, and pharmacists, among others. Moreover, participants in the current study were drawn from not only Ottawa but also the Greater Toronto Area. In doing so, this study hoped to triangulate and add nuances to data gathered from the pilot study.

In total, a gender-balanced sample of 22 IFHP beneficiaries and 21 service providers were interviewed. Four inter-related themes emerged from these interviews: (1) IFHP illiteracy; (2) coverage gaps under IFHP; (3) health access barriers facing IFHP beneficiaries; and (4) administrative hurdles facing IFHP service providers. These themes largely echoed the findings of the pilot study. Together, they showed that IFHP's reinstatement alone had not completely eliminated the health care access challenges that refugees and refugee claimants faced during the years of IFHP cuts. For both beneficiaries and service providers, a high level of confusion about the content of IFHP was observed. This negatively affected IFHP beneficiaries' comfort with accessing health care, as well as service providers' willingness to take on IFHP clients. As a result, even under the current IFHP, some beneficiaries still struggled with finding service providers that would accept them as patients, and they sometimes were asked to pay for health care services or products that should have been publicly covered.

Going forward, Canadian government must devote more attention to educating refugees, refugee claimants and service providers about IFHP and to answering their questions about the program. Such public education must be done in a way that is carefully tailored to the needs and circumstances of the specific audience. Stakeholders' complaints about IFHP's coverage gaps and administrative hurdles must also be followed up by the government. To the extent that these complaints are on the mark, their timely resolution by the government will be key to ensuring that IFHP accomplishes the objectives of protecting refugees' and refugee claimants' health and safety.

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1. Introduction

1.1. Policy Background

For decades, Canada's Interim Federal Health Program (IFHP) has provided temporary health care coverage to refugees and refugee claimants who are not eligible for provincial/territorial health insurance and are unable to pay for their medical expenses privately.

Prior to June 30, 2012, refugee claimants were eligible for both basic and supplemental health coverage under IFHP. Whereas basic coverage consisted of medically necessary and medically required services comparable to those covered under provincial/territorial health insurance, supplemental coverage included additional health-related support akin to those provided by provincial/territorial social assistance programs, such as prescription drugs, basic vision care, emergency dental care, long-term care, and certain medical devices.¹ Resettled refugees including government-assisted and privately-sponsored refugees, being permanent residents in Canada, received basic coverage through provincial/territorial health insurance, but they were entitled to the supplemental portion of IFHP benefits typically for one year upon arrival in the country.

Between June 30, 2012 and April 1, 2016, however, the scope of health care services that IFHP covered was significantly reduced. No longer affording the same level of health care benefits to all refugees and refugee claimants respectively, coverage under IFHP during this time became stratified.²

Until November 2014, IFHP divided its beneficiaries into four tiers:

- Expanded health care coverage: The only groups of refugees that maintained the same level of health care coverage as what they received prior to June 30, 2012 were government-assisted refugees and those under immigration detention.
- Health care coverage: Privately-sponsored refugees and refugee claimants from countries other than those considered by Canada as safe and unlikely to produce genuine refugees—i.e. “designated countries of origin”—had their supplemental coverage largely eliminated and their basic coverage reduced to including only urgent or essential health services. As a result, they were stripped of coverage for many primary and preventive care services.
- Public health or public safety health care coverage: All refugee claimants from “designated countries of origin,” as well as refugee claimants whose asylum application had been rejected, were only eligible for receiving services deemed necessary to address diseases posing a risk to public health or public safety. This meant, for example, pregnant refugee claimants coming under this category no longer had publicly funded maternity care, given that pregnancy was not a condition of public health or public safety concern.
- No coverage: Refugee claimants considered to have abandoned or withdrawn their asylum applications, along with prospective deportees who had requested a pre-removal risk assessment, were excluded from IFHP altogether.

Under exceptional and compelling situations, the federal Immigration Minister had the discretion to provide refugees and refugee claimants health care benefits that they were otherwise not eligible for.

¹ *Information Sheet for Interim Federal Health Program Recipients* (Ottawa: Citizenship and Immigration Canada, 2011).

² *Order Respecting the Interim Federal Health Program, 2012*, S.I./2012-26, C. Gaz. 2012.II.1135.

These changes created much confusion about whom and what was covered by IFHP, which negatively affected the health of refugees and refugee claimants. In the wake of the 2012 cuts, some individuals that were eligible for IFHP were mistakenly denied services, some were asked to pay for the cost of care up front, and many health care providers opted to stop accepting IFHP patients completely.³

In November 2014, after the Federal Court ruled the changes made to IFHP in June 2012 were unconstitutional,⁴ the federal government introduced a third version of IFHP.⁵ Although this iteration of IFHP entitled refugees and refugee claimants to a broader set of health care benefits, it still fell short of what IFHP used to cover before June 30, 2012. Under this partially-restored IFHP, all refugees and refugee claimants below the age of nineteen saw their health care entitlement returned to the pre-2012 level, consisting of both basic and supplemental health coverage. Refugees and refugee claimants who were pregnant were granted coverage for basic health services and prescription drugs. Moreover, no longer were refugee claimants divided into those from “designated countries of origin” and those from elsewhere. All refugee claimants became eligible to receive basic health coverage and prescription medication, if the latter was required to alleviate concerns of public health or public safety. However, unsuccessful refugee claimants, people whose asylum application was deemed withdrawn, abandoned or suspended, and applicants of a pre-removal risk assessment continued to receive minimal, if any, health care coverage under IFHP.

While the changes made to IFHP in November 2014 were welcome news for many refugees and refugee claimants, the creation of yet another coverage scheme instead of simply reinstating IFHP to its pre-2012 form added to the confusion about the program.⁶ On April 1, 2016, following a change in government and persistent advocacy efforts from affected communities, coverage under IFHP was largely restored to its pre-2012 level.⁷ This reinstatement, according to the government, “helps to protect the health and safety of [IFHP] beneficiaries and Canadians.”⁸

1.2. Rationale for Current Study

There has been a dearth of academic writing that explores whether and how the reinstated IFHP is meeting its stated aim of protecting refugees’ and refugee claimants’ health and safety. Studies have shown that laws and policies ostensibly providing robust health care entitlement on

³ “Health Care for Refugees” (25 February 2013), online: Canadian Association of Refugee Lawyers <<http://www.carl-acadr.ca/our-work/issues/IFHP>>; Helen P Harris & Daniyal Zuberi, “Harming Refugee and Canadian Health: The Negative Consequences of Recent Reforms to Canada’s Interim Federal Health Program” (2015) 16:4 J Intl Migration & Integration 1041.

⁴ *Canadian Doctors for Refugee Care v. Canada (AG)* (2014), 28 Imm. L.R. (4th) 1 [CDRC].

⁵ Citizenship and Immigration Canada, *Interim Federal Health Program Policy* (13 November 2014), online: CIC <www.cic.gc.ca/english/department/laws-policy/ifhp.asp>.

⁶ See e.g., Ritika Goel, “What you need to know about Canada’s refugee health program” *Huffington Post* (25 December 2014), online: Huffington Post <www.huffingtonpost.ca/ritika-goel/canada-refugee-healthcare_b_6104694.html>; Valentina Antonipillai et al, “Impacts of the Interim Federal Health Program Reforms: A Stakeholder Analysis of Barriers to Health Care Access and Provision for Refugees” (2017) 108:4 Can J Public Health e435.

⁷ Michelle Zilio, “Liberals Restore Health Care to Refugees”, *The Globe and Mail* (19 Feb 2016) A3.

⁸ “Interim Federal Health Program: Review the Policy” (last modified 19 April 2021), online: Government of Canada <<https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/interim-federal-health-program-policy.html>>

paper do not necessarily by themselves ensure migrants' health care access.⁹ Reinstatement of the IFHP in 2016, without more, may or may not adequately protect the health of refugees and refugee claimants. Even before the 2012 changes, health care access for IFHP beneficiaries had already been problematic.¹⁰ Health care providers were known to not accept IFHP patients because they either were unfamiliar with the program or found its reimbursement process too cumbersome and time-consuming. It was particularly difficult for refugees and refugee claimants to access health care services and devices that were deemed high-cost or elective as their coverage under IFHP required pre-approval from the program's administrator.

To shed light on the performance of the reinstated IFHP—whether it has improved the accessibility of health care for refugees and refugee claimants, and whether some of the shortcomings predating the 2012 changes have resurfaced—the author joined Professors Vanessa Gruben and Jamie Liew to undertake an exploratory study in spring 2017.¹¹ We interviewed 11 refugee service providers in Ottawa, whose professions ranged from nurses to mental health counselors to health care administrators. We learned that, from a service providers' perspective, while there have been notable improvements to refugees' and refugee claimants' health care access since 2016 when compared with the situation during the years of IFHP cuts, ongoing problems with the program remain.

First, IFHP coverage contained certain gaps. Some services such as psychotherapy and medical interpretation were not adequately covered, and certain health care practitioners did not receive sufficient compensation. Second, the reinstated IFHP was seen as mired in “a legacy of confusion,” as some providers still denied services to IFHP patients due to mistaken beliefs that these patients lacked adequate health care coverage. Third, the administrative requirements imposed by Medavie Blue Cross, the insurance company contracted by government to administer IFHP, was perceived as burdensome. The process for health care practitioners to register as an IFHP-approved provider was considered too demanding by some. The billing process also appeared uneven: some providers reported timely reimbursement from Medavie Blue Cross, whereas others complained of long delays. These findings, albeit preliminary, suggest the current IFHP may come short of realizing its full potential to protect refugees' and refugee claimants' health.

To gain a fuller picture of how the reinstated IFHP was working and to more deeply explore the issues that were identified in the pilot study, the current research project was initiated in summer 2018. It sought to expand on the pilot study in several ways. Foremost, interviews were conducted with refugees and refugee claimants to gauge the performance of IFHP from service users' viewpoint. A new set of refugee-serving practitioners were also recruited to take part in the study, particularly practitioners from professions that were left out in the pilot, including dentists, optometrists, and pharmacists, among others. Moreover, participants in the current study were

⁹ Charles Watters, “Towards A New Paradigm in Migrant Health Research: Integrating Entitlement, Access and Appropriateness” (2011) 7(3) *Intl J Migration Health & Social Care* 148; Anita J Gagnon, “The Responsiveness of the Canadian Health Care System Towards Newcomers” in Pierre-Gerlier Forest, Gregory Marchildon & Tom McIntosh, eds, *Changing Health Care in Canada: Romanow Papers*, vol 2 (Toronto: University of Toronto Press, 2004) 349.

¹⁰ Gagnon, *supra* note 6; Baukje Miedema, Ryan Hamilton & Julie Easley, “Climbing the Walls: Structural Barriers to Accessing Primary Care for Refugee Newcomers in Canada” (2008) 54(3) *Can Family Physician* 335; Joshua Wales, “Interim Federal Health: A Public Health Perspective” (2010) 7 *McMaster U Medical J* 50.

¹¹ Y.Y. Brandon Chen, Vanessa Gruben & Jamie Chai Yun Liew, “A Legacy of Confusion?: An Exploratory Study of Service Provision under the Reinstated Interim Federal Health Program” (2018) 34:2 *Refugee* 94.

drawn from not only Ottawa but also the Greater Toronto Area. In doing so, this study hoped to triangulate and add nuances to data gathered from the pilot study.

2. Methodology

This study aims to assess refugees' and service providers' awareness of IFHP, as well as to examine service utilization and provision experiences under the reinstated program. Given these objectives, a qualitative research method consisting of semi-structured interviews was employed to allow for in-depth examination of people's views and lived experiences.¹²

To recruit refugees and refugee claimants for interviews, flyers containing a brief description of the study in English, French, and Arabic were placed at various locations where newcomers were known to frequent, including settlement services organizations, community health clinics, and community centres. Several refugee services organizations also agreed to distribute an electronic copy of the recruitment flyer to their clients through e-newsletters and/or social media. A snowball sampling technique was further adopted where participants were invited to refer their peers to the study.

Similar strategies were used to recruit service providers. A list of refugee-serving practitioners and health care establishments in Ottawa and the Greater Toronto Area was compiled after consulting key informants, including service providers who took part in the pilot study. Members of our research team then contacted service providers on this list to invite their participation in the study. In addition, selected health professional organizations such as the Ontario Association of Optometrists and the Ontario Physiotherapy Association were emailed a short description of the study with an invitation to their members to participate. Snowball sampling was then used to complement these recruitment efforts.

All told, between July 1, 2018 and July 31, 2020, our research team conducted 40 interviews, involving 22 IFHP beneficiaries and 21 service providers. A profile of these participants can be found in Table 1. Of note, approximately 30% of interviewees from each group were physically located in the Greater Toronto Area, with the remainder in Ottawa. Among the IFHP beneficiaries interviewed, 6 qualified for IFHP as resettled refugees and 16 as refugee claimants. The most common professional backgrounds of the service providers interviewed were dentistry (n=6), pharmacy (n=4), medicine (n=3) and optometry (n=3).

Upon completion of data collection, interviews were transcribed and the transcripts were sent to participants for review. Transcripts of interviews conducted in French or Arabic were translated into English. Once the accuracy of the transcripts was confirmed, they were input into the NVivo software for organization, thematic coding, and analysis.

¹² Shazia Jamshed, "Qualitative Research Method—Interviewing and Observation" (2014) 5(4) J Basic & Clinical Pharmacy 87.

Table 1: Demographic Information of Participants

	IFHP Beneficiaries (n = 22)	IFHP Service Providers (n = 21)
City of Residence		
Ottawa	15 (68.2%)	15 (71.4%)
Greater Toronto Area	7 (31.8%)	6 (28.6%)
Sex		
Female	11 (50.0%)	10 (47.6%)
Male	10 (45.5%)	11 (52.4%)
Unknown	1 (4.5%)	--
Immigration Status		
Resettled Refugees	6 (27.3%)	
Refugee Claimants	16 (72.7%)	
Professional Background		
Medicine		3 (14.3%)
Nursing		1 (4.8%)
Dentistry		6 (28.6%)
Optometry		3 (14.3%)
Pharmacy		4 (19.0%)
Health Care Administration		2 (9.5%)
Refugee Services		2 (9.5%)

3. Results

3.1. Contextualizing Research Findings

Four inter-related themes emerged from our interviews with IFHP beneficiaries and service providers: (1) IFHP illiteracy; (2) coverage gaps under IFHP; (3) health access barriers facing IFHP beneficiaries; and (4) administrative hurdles facing IFHP service providers. These themes largely echo the findings of the pilot study. Together, they show the policy to reinstate IFHP has not completely resolved the health care access challenges that refugees and refugee claimants faced during the years of IFHP cuts. As explained below, even under the current IFHP, some beneficiaries still struggle with finding service providers that would accept them as patients, and they sometimes are asked to pay for health care services or products that should have been publicly covered. Should governments in Canada choose to continue covering refugees' and refugee claimants' health care through IFHP—as opposed to, say, through provincial/territorial health insurance plans—greater efforts must be devoted to educating beneficiaries and service providers alike about the program, as well as to recruiting and retaining IFHP-registered service providers.

Despite these ongoing problems with IFHP, however, the program's reinstatement in 2016, which returned the level of health care coverage for refugees and refugee claimants to one that is comparable to what Canadians receive, was broadly praised by our interviewees. As one service provider (S16) remarked:

“Yeah, so absolutely it's better than the years of cuts in that we've gone back to the state of pre-2012. That means if someone is an active refugee claimant, we're able to get them most things that would have been covered on OHIP [the Ontario Health Insurance

Plan] and, if you have social assistance, the equivalent to somebody in Ontario receiving social assistance. So, it's much better in that sense, and there isn't any longer that differential access based on country of origin. So, that's great."

Similar sentiments were conveyed by refugees and refugee claimants in our study. Although none had experienced IFHP during the years of cuts in order to make the direct comparison, nearly half (n=10) of them expressed an appreciation for the health care coverage they received under the current IFHP. For example, Participant R18 contrasted IFHP with the level of health care he had received in his former country of residence and noted:

"IFHP is good. It's better than the insurance in [our former country of residence]. ... For IFHP, we have not paid anything, not even a cent. In [our former country of residence], some hospitals will not treat you if you are in a certain [immigration] class. ... There are no classes in IFHP. Everyone is covered the same."

Along the same line, Participant R7, who was a protected person in Canada but had experienced the reinstated IFHP when she was a refugee claimant, compared IFHP favourably with OHIP:

"Well, for me, I prefer the IFHP. 'Cause they actually help more. 'Cause they cover everything. ... Once I get the insurance, the OHIP insurance, they're like 'we're not covering vitamins, we're not covering this, we're not covering that.'"

Given how IFHP stratified its coverage between 2012 and 2016 based on refugees' and refugee claimants' circumstances, leaving many with a level of health care coverage that fell well short of what provincial/territorial health insurance provided, it stands to reason that Participants R18 and R6 would have responded to IFHP's reinstatement in 2016 positively.

As such, the problems raised by our participants concerning the current IFHP are not intended to be an indictment of the program's reinstatement in 2016. Relative to the situations between 2012 and 2016, refugees' and refugee claimants' health care access today is undeniably better. Instead, the issues identified by our participants are more appropriately situated in relation to the purpose behind IFHP reinstatement, which was in part to protect IFHP beneficiaries' health and safety. The four themes emerging from this study, therefore, indicate specific areas for improvement if the stated objective of the reinstated IFHP is to be fully achieved.

3.2. IFHP Illiteracy

3.2.1. IFHP Illiteracy among Beneficiaries

Widespread IFHP illiteracy was one of the concerns most frequently raised by participants in this study. IFHP beneficiaries and service providers alike (n=22) observed that refugees and refugee claimants were often unclear about whom and what IFHP covered, as well as for how long the benefit was supposed to last. For instance, Participant R19 admitted:

"I still myself don't really understand exactly what [IFHP] is. All I know is it's something that you cannot go without. It's a necessity. It's something that you really need. But I never got to sit down and fully comprehend what it is that the IFHP is and what it does for me, as a refugee."

This lack of knowledge about IFHP among the beneficiaries was echoed by service providers, including Participant S1. She noted:

“Our clients do not have enough knowledge of what is covered and what is not. ... No one knows. I have had clients who have two masters. Double masters. And then I have clients who are not even educated in their first language. Like, they don’t have basic literacy skills. And, none [of them understand what IFHP covers].”

When probed further, half a dozen refugees and refugee claimants described having received zero or minimal information about IFHP at the time of being granted coverage. As a case in point, Participant R3 recounted: “[Border officials] do not sit down with you and discuss the IFHP. They just give you a piece of paper [i.e. the IFHP certificate] and say ‘this is important, make copies’.” Similarly, Participant R18 noted: “When [immigration officers] gave us the refugee claimant documents, they said it’s also insurance. But they didn’t give us any details.” Although several participants (n=3) reported learning about IFHP on their own by visiting government websites, more commonly, refugees and refugee claimants (n=7) acquired their limited knowledge about IFHP through other newcomers or their sponsors.

3.2.2. IFHP Illiteracy among Service Providers

Such unfamiliarity with IFHP appeared prevalent among refugee-serving practitioners as well. Nine participants recalled having encountered service providers who were outright unaware of IFHP. As Participant R1 explained:

“Not all of [the service providers know about IFHP]. Some don’t know. It depends on the area you go to, I guess. Some know and some don’t know about it. It’s strange. They would be like, ‘what’s IFHP?’”

Participant R10 provided a similar assessment of service providers’ familiarity with IFHP:

“On a scale of 1 to 10, I think [I would rank service providers’ knowledge about IFHP as] 6. I’ve heard so many providers tell you they don’t have an idea of what IFHP is. Yeah, they’re asking you if it’s from Canada. Is it from Ontario? You know, so... (chuckles).”

To illustrate her point, Participant R10 shared an encounter with a medical receptionist:

“They kind of figured that everyone has the OHIP card. So, she requested for, there is a number on the OHIP card, which ends in two letters. So I told her what I had on my IFHP [certificate], and she was like, she had never heard of that before. I told her it’s the Interim Federal Health Plan. She said she doesn’t know what that is.”

Even when service providers knew of IFHP, however, they were not always knowledgeable about the workings of the program. Approximately a quarter of our participants (n=11) reported having dealt with service providers who were unclear about certain details of IFHP. Another eight service provider participants admitted to being uninformed about IFHP themselves. As an indication of the extent of some service providers’ lack of knowledge about IFHP, one dental professional (Participant S19) confessed to not being aware of IFHP’s reinstatement four years after the policy change. However, more commonly, service providers’ confusion about IFHP concerned the basket of health care services and goods it covered, what served as acceptable documents for confirming a person’s IFHP eligibility, the duration of IFHP coverage and how it interfaced with expiration dates listed on IFHP documents, and the process for seeking reimbursement from Medavie Blue Cross.

Some participants attributed IFHP illiteracy among service providers to the repeated policy changes between 2012 and 2016. For example, Participant S16 reasoned:

“I think we are actually probably not even as good as we were pre-2012. Because what happened with the period of cuts is that it created a lot of confusion among health care providers and because there was so much confusion and then a period of time things were so complicated – figuring out who was covered, what they were covered for. And there were so many different versions of what happened – there was sort of the, what used to be before 2012, and then there was what happened after the cuts, and then there was what happened with the initial forced reinstatement with the Harper government, and then there was what happened with the Trudeau government – that I think people, understandably, were not able to keep track of what was going on, and who was covered.”

Other participants pointed to the infrequent encounter that some service providers had with refugees or refugee claimants as another reason for their unfamiliarity with IFHP. As Participant S11, a pharmacist, explained:

“Part of additional steps [when working with refugees] has to do with the fact we don’t treat refugees very often, constantly refreshing ourselves because it’s been a quarter. We didn’t realize because one of the last times we served a refugee as part of this program was right around the time the program had changed and [the client] had just come to Canada. ... We’ve seen it so infrequently so it’s a steep learning curve.”

Still another contributor to service providers’ confusion about IFHP, according to our participants, was the disparity between various government health and social care programs. The following comments from an optometrist, Participant S15, is illustrative of this:

“Sometimes there are a lot of different coverage types out there. So, there is the ODSP [i.e. Ontario Disability Support Program] and Ontario Works [i.e. Ontario’s social assistance program], and there’s IFH and Indian Affairs, for example. So, sometimes there can be a bit of complication, at least on my end, or on my staff’s end, to kind of have to remind ourselves what is covered versus what is not covered for [refugees]. For example, like special testing, visual appeals, is covered under one insurance but not the other, so sometimes that can take a little bit more learning. It would be, obviously, in an ideal world, nice if it was more streamlined, so we don’t have to go through that conversation with patients, like ‘oh sorry, we did this on you and we thought it was covered, but it’s actually not’.”

3.2.3. Consequences of IFHP Illiteracy

In turn, such confusion about IFHP was said to have had the effects of tarnishing refugees’ and refugee claimants’ health-seeking experience. Several IFHP beneficiaries complained about having to wait longer than others before being served by health care providers because the providers did not immediately know what IFHP was or how to process IFHP coverage. Participant R1 recounted one such instance:

“Yeah, that was a while (emphasis) that took. [The pharmacist] was like, she never, she was kinda confused as to how to use [the IFHP document] because it didn’t look like a regular [health insurance] card. ... She took, like I said, a long time to figure out that

something isn't right, and she had to call. I don't know who she had to call. She had to call someone."

Participant R16 likewise described having to wait nearly half an hour at a pharmacy one time for the pharmacist to figure out how IFHP worked, which he thought was "a little too long."

At times, IFHP illiteracy might even impede refugees and refugee claimants from accessing certain health care completely. This could occur because IFHP beneficiaries mistakenly thought certain services or products were not covered by the program. Or it could happen as a result of IFHP beneficiaries' hesitancy to utilize services whose coverage under the program they were unsure of. As Participant R16 said:

"In some cases, I don't know what's covered. So, I'm not going to go and embarrass myself and then like, 'oh yeah, I have this [coverage]', and they'll be like, 'oh no, that doesn't work here'."

IFHP beneficiaries might also lack the necessary familiarity with the Canadian health care system in general to know how to access the services they were eligible for. This was especially so if the services sought by IFHP beneficiaries required a high level of coordination. Participant S20 explained this in the context of home care, which could involve a range of practitioners from personal support workers to physiotherapists to nurses:

"I think that there needs to be some kind of facilitator role for the IFH program in general because a lot of times it's just people trying to figure it out. ... Because the expectation that people know who to engage the health services available through IFH when they are refugee newcomers is unrealistic. If I ask someone in my own family, who has been born and raised here, to try and coordinate their own health services, in this manner, they wouldn't be able to. To expect someone who has just arrived or are someplace in their post-migration period to try and navigate a system that is not in their mother language, that they are not familiar with, they don't even know what services could be available to them, they don't know where to find this information. They are not given like a pamphlet when they come – 'this is where to find the information when you need for these services'. So, it's very challenging. ... So, they say 'great, we will fund these services' and you don't know how to access them. It's like having a bridge to nowhere in some sense."

In other cases, IFHP beneficiaries were denied access to health care because of service providers' misinformation or confusion about the program. Participant S9, whose professional role was to help resettled refugees navigate the health care system, observed:

"One other thing I want to say is that not all healthcare staff know how the IFHP system works. They'll put the form through, and they say 'oh it didn't go through, she's not eligible', and one person said she wasn't eligible because she had OHIP which wasn't true. I took her to someone else to have her tested, and there it went through because the staff was very familiar with newcomers and IFHP. But twice, once in a pharmacy and once at a healthcare provider, the IFHP didn't go through because the staff didn't know what they were doing and blamed it on us basically."

Had Participant S9 not intervened, the refugee in question would have not received the health care she sought. Such negative impacts of service providers' confusion about IFHP on refugees' and refugee claimants' health care access will be revisited in subsection 3.4.

3.3. Coverage Gaps under IFHP

3.3.1. Gaps in Dental Benefit

Another complaint commonly levelled against IFHP by our participants (n=34) concerned gaps in the program's coverage. Specifically, dental coverage under IFHP was most frequently identified (n=20) as inadequate. Among other things, the fact that IFHP covered the cost of tooth extraction but not a root canal troubled many. Participant S6, a dentist, explained his concern:

“Honestly, what [the government needs] to do is to define the objectives of the program. What is this program all about? Because if someone comes in and they are in dire situations and they are in pain, and that tooth is an excellent tooth that happens to need a root canal treatment, [IFHP is] going to deny it. So, the only course is to have the tooth removed or extracted. I don't know. I don't know about you guys, but I feel very uncomfortable taking out a tooth that is solid as a rock in somebody's mouth that can otherwise be saved by a root canal treatment.”

Given the lack of IFHP coverage, refugees and refugee claimants in need of root canals had had to incur significant out-of-pocket expenses, often thousands of dollars, to attain the procedure. For those who could not afford such costs, the choice between living with severe toothache and undergoing tooth extraction was not always ideal. For example, Participant R22 described her hesitation to have her teeth extracted while pregnant:

“And for a dentist I have bad experience. ... I think the dentist is too expensive in Canada. It is not covered [under IFHP]. It is just for emergencies to extract teeth. They offer you removal of teeth for free. Any other services you have to pay. I lost a tooth because I was pregnant and my immune system was down and I got problems in my molar. And they say the only thing is we can remove it for free but if you want to root canal, you need to pay around \$2,000, which was too much. And we say remove. And when they put anaesthesia in my molar, I was scared it would hurt my baby, but there was no other option. The dentist is too expensive.”

In the same vein, Participant S2 recalled having a client who preferred not to have his teeth extracted because the subsequent cost of replacing the missing teeth—via either implants or partial dentures—would not be covered by IFHP in his case. This decision, in turn, placed the refugee client's health in jeopardy. Participant S2 explained:

“[I have] another client who needed to have heart surgery and he was referred by the cardiologist to a dental clinic to really figure out his teeth issues. He can't do major heart surgery without controlling all the major issues in his teeth. That he really needed to take six teeth out, like molars. It was really a disaster for him because he would not have any coverage [under IFHP] to get these teeth replaced and they are all molars. ... So, he delayed his major heart surgery because of that.”

Besides the unavailability of root canal treatments, a handful of participants were dissatisfied with the lack of IFHP coverage in relation to preventive dentistry such as routine teeth cleaning and checkups. They questioned the cost-effectiveness of this policy choice. As Participant R16 lamented:

“I was told that I had to pay \$120 for the cleaning. It's not covered by the IFH, and I was thinking to myself, 'hell, I might as well let it rot, and you just take them out and put some dentures in'. ... I mean, I'm not saying I don't want to do [the cleaning]. I just

don't have the money to do it. And if I don't do it, according to the dentist, I could end up having several extractions. ... That kind of sounds bad. It's like saying, the federal government is saying, 'yeah, you can let your teeth rotten out, we can take it out for you and we can fill it for you, but to hell with cleaning it'. But I'm like, that's a waste of money, because if you clean it, it'll be cheaper, and just teach people to brush their teeth, then you wouldn't have to spend that kind of money on a dental plan."

One dentist, Participant S13, pointed to IFHP's lack of coverage of sedatives that might be required during dental procedures as another gap, especially for beneficiaries experiencing post-traumatic stress. She observed:

"With these refugee patients, a lot of them have post traumatic syndrome and so on. Like I had patients that were captured and tortured and so on. I had patients with anxiety and of course the dentist's office is not the best place for people with anxiety at all. So, a lot of these patients need some sort of sedation to be treated and unfortunately that's absolutely not covered with this [IFHP] insurance. We use laughing gas or nitrous oxide gas, and the laughing gas cost is usually, it's quite expensive actually. For me, I had to use it multiple times where I wouldn't send for insurance because they wouldn't cover it, and whatever they might cover if I had to fight and send a letter, it would be very very minimal."

Given the shortcomings in IFHP's dental coverage, service providers reported to have regularly turned to other free dental services in the community to address refugees' and refugee claimants' needs. A Toronto-based physician (Participant S17), for instance, commented:

"Dentistry has always been a struggle. ... The problem with dentistry was that IFH just didn't pay like other insurance programs. The coverage is very rudimentary, so even when we find [an IFHP-registered dentist], it's often for extractions. Again, in a city like Toronto we will often rely on Toronto Public Health Dentistry to fill in those gaps. So, completely work around the IFH program."

Such workaround, however, might sometimes be impossible. Not all refugees and refugee claimants are eligible for these alternative dental care programs, nor do they all live in a city where such alternatives exist. Moreover, access to these other free dental services often require refugees or their service providers to know about them in the first place, which is not always the case.

3.3.2. Gaps in Prescription Drug Benefit

Next to dental services, prescription medication was the most commonly identified gap relating to IFHP coverage (n=13). Considering that the breadth of prescription drugs covered under IFHP largely mirrored that of provincial/territorial formularies,¹³ participants' complaint primarily centered on the exclusion of over-the-counter medicines from IFHP coverage. The nature of such a concern was well articulated by Participant S9:

"There's some things that aren't covered, like over-the-counter medication. And that can worry [refugees] because it can be a high cost to them. This would be another

¹³ "Prescription Drug Coverage" (last visited 23 August 2021), online: *Medavie Blue Cross* <https://docs.medaviebc.ca/providers/benefit_grids/ifhp_benefit_grid__prescription_drug_coverage.pdf?mtime=20181205115932>.

recommendation: IFHP should cover things over the counter that people need to feel better: headache pills, stomach remedies, things that they will feel miserable without. That adds up financially. Anything over the counter at all is generally not covered.”

Although some over-the-counter medicines could potentially be replaced by prescription drugs that were covered by IFHP, this type of substitution might not be appropriate sometimes. Participant S11, a pharmacist, elaborated on this point while describing the difficulty of communicating this fact to refugee clients who were expecting to get all the doctor-recommended medications:

“I’ve also had issues where a physician out of goodness of his heart, and maybe not even understanding himself what is or is not a benefit [under IFHP], just kind of assuming that everything gets scooped up one way or the other because of what is provided to take care of refugees, will write out over-the-counter medication. For example, I’ll get a refugee, let’s say, who has seasonal allergies and maybe he orders the newest antihistamine on the block like Blexten and steroid nasal spray and an eye drop that is over the counter. I have to try to explain to [refugee clients] that this is not a benefit, but something similar would be, and I’ve got to get it changed. This over-the-counter medication is not paid for. If you want it, you have to buy it, and there isn’t anything equivalent. I’m not going to ask a doctor to prescribe a potent prescription medication when an over-the-counter medication will do, right? It’s like killing an ant with a sledgehammer. So, you’re kind of caught between a rock and hard place. Because I could contact the physician and say, assuming this is a benefit with the program, you could give them a more powerful eye drop, but ... [Interviewer: there is a risk to doing that?] Yeah.”

3.3.3. Gaps Relating to Other Benefits

Other gaps in IFHP coverage that were identified by our participants included certain vision care, homecare, and interpretation services. With respect to vision care, all three optometrists interviewed (Participants S14, S15, and S18) expressed a desire for IFHP to cover more diagnostic tests, including retinal imaging. Two of them mentioned the need for IFHP to cover the cost of more follow-up visits—beyond the one complete and one partial eye exam that were presently included annually—especially for clients with more complex eye conditions. Participant S18 further suggested adding sunglasses to IFHP’s eyewear coverage, noting “a lot of [IFHP] clients come from places that have caused a lot of sun damage in their eye and they do require some sort of sun protection.”

Regarding homecare, shortcomings observed by our participants concerned out-of-pocket expenses that IFHP beneficiaries could incur, as well as how physiotherapy and occupational therapy benefits were structured. Participant S20 raised both issues in her interview. On the issue of out-of-pocket expenses, she explained how these could arise when IFHP covered the cost of homecare equipment but not the attendant shipping and installation fees:

“There are also issues of certain fees that are not covered, which can be difficult for [IFHP] clients and families, like the installation of equipment and delivery of supplies that can be very costly. IFH doesn't cover it. And those were things I didn't realize perhaps until after the first or second time that I had ordered or requested these things. After the fact, the family has a bill they have to then pay that they didn’t expect.”

As for physiotherapy and occupational therapy, Participant S20 expressed some concern about the rigidity of how these benefits were covered under IFHP. At present, per calendar year, IFHP would pay the costs of one home visit by either physiotherapists or occupational therapists for an initial assessment, plus 12 subsequent home visits by physiotherapists or 20 visits by occupational therapists.¹⁴ When compared with OHIP, although IFHP seemingly covered more home visits by these health practitioners, the frequency limit for these services was absolute, even if beneficiaries' therapeutic needs might have changed. As Participant S20 explained:

“Technically, when you're OHIP funded, you can have an OT [i.e. occupation therapist] come see you for one issue, might take three visits. But let's say your status changes significantly, like you have an accident, or something happens, you can have another OT referral for an additional three, five visits if that's required. Because your issue is new and your circumstances have changed and you require that, you require different equipment and you need a new assessment. Whereas IFH, you have one in-home assessment and 10 [sic] visits maximum per calendar year and you have no flexibility in that. So, if you have your OT visits and you require that block of 10 [sic] visits, let's say in the first half of the year and then you sustain an injury, an accident, and your circumstances have changed, you wouldn't have access to those again, until the following year. It doesn't matter if your situation has changed.”

The need for IFHP to pay for more interpretation services in the course of refugees' and refugee claimants' health care use was raised by four service provider participants, three of whom were pharmacists. While IFHP does cover some interpretation and translation-related costs now, the coverage is restricted to interpretation and translation required during refugees' Post Arrival Health Assessment and when IFHP beneficiaries receive psychiatric care, psychotherapy or counselling.¹⁵ Our pharmacist participants, however, identified language barrier as a significant challenge in their dealings with refugee and refugee claimant clients, and they stressed the importance for them to have greater access to interpreters. Consider Participant S12's comments, for example:

“The issues that do arise with the patients that come in who are refugees is that oftentimes, most of the time, the language barrier. The language barrier is a huge, huge thing. It's not always the case, but it is often the case. Explaining to patients not only what they're covered for but also what they're not covered for, also explaining to them how to use this medication, and how often they should use this medication. I think these barriers are the most difficult part. ... [If] they can't express themselves and we are unable to understand them, it does raise issues, miscommunications issues.”

Participant S20 made a similar case for greater interpretation coverage in the homecare context:

“And interpretation of course, I feel needs to be funded because having someone access a physiotherapist when they can't understand what that person is trying to teach them is not effective, not equitable health service access. It really, really limits the interventions that are available. Not having interpretation funded through the [IFHP] seems like giving someone a gift that they can't open.”

¹⁴ “IFHP Benefit Grid – Supplemental Coverage” (last modified 13 March 2020), online: *Medavie Blue Cross* <https://docs.medaviebc.ca/providers/benefit_grids/IFHP-Benefit-Grid-Supplemental-Coverage-2020-EN.pdf?mtime=20200715140307>.

¹⁵ *Ibid.*

3.3.4. Consequences of IFHP Coverage Gaps

Understandably, given limited public resources, it would be hard-pressed for IFHP to cover the costs of every health care service and product available on the market today. And indeed, IFHP does not purport to be comprehensive in its scope.¹⁶ That being said, the reasonableness of IFHP's exclusion of certain services or products from its coverage is a valid inquiry, particularly when juxtaposed with the program's stated objective of protecting IFHP beneficiaries' health and safety.

As already alluded to, seeing as most refugees and refugee claimants have much difficulty paying for services privately, when medically necessary services are left out of IFHP coverage, their health and wellbeing could be undermined. Inadequate dental benefits under IFHP, for instance, discourage refugees and refugee claimants from accessing preventive services while restrict treatment option for decayed or diseased teeth to extraction, which is not suitable for some people. This is especially so when the cost of replacing the extracted teeth is not publicly covered. Similarly, IFHP's limited coverage of interpretation and translation in health care settings risks rendering many IFHP-covered services illusory for beneficiaries, as language barriers are known to interfere with their service access, as well as comprehension of service providers' instructions.

Furthermore, the exclusion of certain health care services or products from IFHP coverage, when not clearly explained to beneficiaries and service providers, can add to the confusion about the program. The problem raised above by Participant S11, where physicians write down both prescription drugs and over-the-counter medicine on the same script without properly informing patients that the latter would not be covered by IFHP, represents one of such scenarios. Another pharmacist, Participant S8, recounted a similar situation and described the occurrence as "quite a bomb, because it's hard to communicate effectively to the patient that not everything is covered and they were really confused." As such, to the extent that the government finds it reasonable to not cover certain health care services or products under IFHP, it would do well to communicate such exclusion clearly. As Participant S17 noted:

"There are some things that are not covered, and it always has been a bit difficult to determine that. So, things like some types, well, permanent contraception. So, vasectomies, tubal ligation are not covered. We found out that long term care is not covered. It would be wonderful to have that detailed somewhere. Just to let clinicians know where the disparities [are] to provincial health insurance. Because in terms of wording, it's been a while since I've looked, but last time I checked on the website, you know the suggestion is [IFHP coverage is] similar to what is covered by provincial health insurance. But making those distinctions would be very helpful."

3.4. Health Access Barriers Facing IFHP Beneficiaries

3.4.1. IFHP Illiteracy-Related Access Barriers

Nearly half (n=21) of the participants indicated having personally experienced, or having had clients who experienced, difficulty accessing services that were covered by IFHP. Such access

¹⁶ "Interim Federal Health Program: What Is Covered" (last modified 19 April 2021), online: Government of Canada <<https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html>>.

barriers, as mentioned, partly stemmed from IFHP beneficiaries' and service providers' illiteracy about the program. Given refugees' and refugee claimants' confusion about their entitlement under IFHP, they often depended on service providers to inform them the health care services and products they were eligible for. Consequently, when service providers were misinformed about what and whom IFHP covered, they could erroneously deny care to refugees and refugee claimants, or cause refugees and refugee claimants to refrain from accessing their entitled benefits. Participant R21's experience served as a case in point:

“My doctor's office had told me that that the IFHP did not cover a broad spectrum of medications and one of those medications was the medication that I was on, and I was like, 'oh okay'. And it was only until like I went downstairs to the pharmacist and the pharmacist told me that it is covered. So, kind of confusing right?”

Had the pharmacist not intervened in this situation, Participant R21 might not have been able to access the medication that she actually had coverage for under IFHP. Not to mention, the misinformation communicated to Participant R21 could have further spread in the community, thus deterring other refugees and refugee claimants from accessing the same medication. Indeed, in the same interview, Participant R21 also described not visiting a speech pathologist to treat her apraxia despite her desire to do so and the fact that the cost of such therapy would have in theory been covered by IFHP, because she had apparently learned the opposite from someone in the community.

3.4.2. Out-of-Pocket Expenses

Another impediment to refugees' and refugee claimants' health care access under IFHP, according to our participants, was the out-of-pocket expenses that they could sometimes incur. For refugees and refugee claimants who could not afford such private expenses, their health care use might be delayed, if not completely obstructed. Even for those who could afford to pay out of pocket, these outlays added to their financial burden, which could get in the way of their resettlement in Canada.¹⁷

To be sure, out-of-pocket expenses at issue are not imposed by IFHP, as the program provides first-dollar coverage for all the benefits. On Government of Canada's website, IFHP beneficiaries are specifically warned:

“Your health-care provider **should not** ask you to pay for IFHP-covered products and services at any time. If you're eligible to get coverage for something, we'll reimburse your provider directly. If you pay your health-care provider for a product or service that we cover, we **won't** reimburse you for it.”¹⁸

Instead, out-of-pocket expenses reported by our participants were largely a result of service providers' IFHP illiteracy and coverage gaps under IFHP.

¹⁷ See e.g. M. Stewart et al, “Challenges Faced by Refugee New Parents from Africa in Canada” (2015) 17 J Immigrant & Minority Health 1146.

¹⁸ “Interim Federal Health Program: Get Health Products and Services” (last modified 11 January 2021), online: Government of Canada <<https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/services.html>> [emphasis original].

First, related to the preceding discussion on how IFHP illiteracy could impede health care access, out-of-pocket charges might be levied by service providers when they incorrectly thought the services or products sought by IFHP clients were not publicly covered. Participant S21, a nurse practitioner, gave an example:

“I come up against brick walls all the time. I spent 45 minutes on the phone with my IFH yesterday, trying to get a patient’s medication covered that should have been covered, and the pharmacist said, ‘I don’t know, I billed them \$300 for their insulin’. And now they’re out of it again and is going to be billed another 300 even though it’s covered. So, [the pharmacist is] not going to do anything. This patient has coverage for their medication, so I spent all this time on the phone, which is not a great use of my time, but who else is going to do it, right? That client should never have been billed in the first place. So, we run into that a lot where providers are minimally willing to do any extra effort whatsoever.”

Second, and as Participant S20 observed earlier in the homecare context, refugees and refugee claimants might be confronted with out-of-pocket expenses when seeking certain medical devices or equipment (e.g., ventilators, oxygen tank, etc.), whose costs were covered by IFHP but not the fees associated with delivery and/or installation. If IFHP beneficiaries were unable to pay these attendant fees privately, the medical devices or equipment in question, albeit publicly covered, would be out of their reach for all intents and purposes.

The third situation where IFHP beneficiaries could be asked to pay out of pocket related to the practice of extra-billing. Extra-billing occurs when health practitioners who are already expected to be reimbursed by an insurance program for an insured service, charge beneficiaries an additional fee for the same service. Although extra-billing is banned under provincial/territorial health insurance plans,¹⁹ no such prohibition exists under IFHP. In fact, the quote above from Government of Canada warning IFHP beneficiaries not to pay health care providers directly for an insured service or product implicitly acknowledges the possibility of extra-billing.

Two participants in our study confirmed the practice of extra-billing by some IFHP service providers. Participant S20, again, described the occurrence of extra-billing in the homecare setting, attributing the practice to IFHP’s supposedly below-the-market reimbursement rate. She explained:

“For PSW [i.e. personal support worker] services, ... IFH will fund 140 hours for the calendar month, whereas provincial maximums are lower than that. But the funding amount, the dollar amount is \$24-25 per hour for PSWs [under IFHP]. ... The lowest cost of actual PSWs is actually \$28 an hour for the companies that I work with. The other one is \$35 an hour. So, the [refugee] family has to pay the difference for each hour used. Despite the fact they have access to potentially more hours of service, the clients are paying out of pocket. Whereas OHIP funded services, for PSWs, they wouldn’t have to pay out of pocket for the services that they are eligible for, that they couldn’t afford themselves.”

Another service provider, Participant S1, recounted a client’s experience of being extra-billed by a doctor’s office:

¹⁹ *Canada Health Act*, RSC, 1985, c C-6, s 18.

“So that client, it's a family of three. Their doctor retired, so they didn't have a family physician anymore, and now I had to find another family doctor or primary care provider for them. Now, that particular doctor speaks the language of the client, which is good. ... But, when I call to the doctor's office, they said, 'well, we are charging \$50 per visit for every IFHP'. ... Yeah, so I'm like, 'no, this person has IFHP'. And they're like, 'yes, this person has IFHP, but that is how we work'. ... I said, 'well, this is a wrong practice'. ... And then she came back and then she's like, 'but yes, that is what we do'. So, I was wondering what allows physicians to charge their patients \$50 each time.”

3.4.3. Difficulty Finding IFHP Service Providers

Besides misinformation from service providers and out-of-pocket expenses, IFHP beneficiaries' health care access was frequently stalled by challenges with finding health practitioners who were willing to accept them as clients. In fact, this was the most common service access barrier (n=17) mentioned by our participants. The story of Participant R20, who lived with HIV and was having a hard time securing a family physician to monitor his health and prescribe him necessary medication, exemplified this problem. He said:

“I tried to find a family doctor, but maybe ten, fifteen different doctors, clinics, hospitals I called. They don't accept me. They said, when they heard, I know it's not about exactly HIV situations. It was about refugee. I was so mad. Then I think, last two, three phone calls I fight them. I said many bad words. I said, 'that is enough'. When I start the conversation with [them], everything is normal. But when I said I am a refugee, they say, 'ah sorry, we do not take refugees'. I said, 'okay, at the time same time I am a human, too'. What is the difference between temporary residents, refugee or citizen? I am human. So, some of them, hang up the phone in my face. Some of them [said], 'you are right, but our policy is like this'. Some of them [said], 'you are really right, ... we take care of refugees but only appointment six months later'. ... They don't care, or they don't take patients that are refugees. My first, more than three months, three months [here in Canada], almost every day I try to find a family doctor.”

Although Medavie Blue Cross regularly compiled a publicly-accessible list of IFHP-registered service providers in each province/territory,²⁰ some participants found the list not up to date. As Participant S9 complained:

“I have a list that IFHP puts out with the latest health providers. But it's usually out of date. So, I have to make phone calls and figure out where [refugee clients] can come. ... I do think that it's hard for IFHP to keep up with which health provider has left the program and who has stayed in. It's not unusual for me to get on the phone and find that a person on the list isn't taking newcomers anymore, or they have retired, etc. So, I do spend a fair amount of time trying to track down who on the list is still operative.”

To avoid this problem, some service providers in this study reported to have developed the practice of only referring refugees and refugee claimants to colleagues that they knew were accepting IFHP clients. But such a strategy would require IFHP beneficiaries to be connected in the first place to some service providers who are both knowledgeable and willing to make the referrals. Moreover,

²⁰ “IFHP Providers: Search IFHP Providers” (last visited 23 August 2021), online: Medavie Blue Cross <<https://ifhp-pfsi.medavie.bluecross.ca/en/search-ifhp-providers/>>.

this workaround would not solve the situations where there are simply no appropriate IFHP-registered service providers to be referred to. To wit, IFHP beneficiaries might reside in smaller communities that have limited number of health practitioners, or they might require highly specialized services that are attainable from only a small number of providers. In these cases, if none of the handful of service providers would accept IFHP clients, the health care benefits offered under IFHP would essentially be illusory. The same concern could also arise if IFHP beneficiaries for some reason prefer not to work with a particular service provider, but this service provider happens to be the only one in the area that would see IFHP patients. Participant S20 gave an example of this:

“There’s only two [staffing agencies for PSWs] in our area that will accept IFH funding, so it’s this one or that one. ... It feels a bit less protected for the [IFHP] clients. ... Again, for therapy as well, there are so few organizations that will accept the funding, that [IFHP beneficiaries] lose the ability to choose. So, if they don’t want to accept an OT from this company, they are the only company that accepts IFH funding. So, if they don’t like that company, they may not have access to OT services, unless they want to pay out of pocket or until they have an OHIP card.”

When service provider participants were asked why they, or their colleagues, might not accept IFHP beneficiaries as clients, they offered a few reasons. First, before service providers could be reimbursed by IFHP, they must have registered with the program. So, unless clients were willing to pay out of pocket, service providers who were not registered—say, if they never heard of IFHP—might decline to serve IFHP clients because they would not be remunerated. Such a registration requirement was criticized by several participants, who saw it as giving service providers a way out of treating refugees and refugee claimants. Participant S16 explained her trouble with the registration requirement as follows:

“I think even just the whole idea of having to have physicians register as IFH providers, I think is very problematic, because it essentially allows people to self-select out of seeing a very vulnerable population. And I just don’t know how we can ethically say that that’s okay. ... I mean, you can’t do that with anything else, right? You can’t say, ‘I don’t see, you know, people from Somalia’. You can’t say that. But to be able to say ‘I don’t see refugees, I don’t accept this insurance’ I think is, again, it’s sort of like a structural discrimination piece that I think should be looked at.”

The repeated policy changes respecting IFHP between June 2012 and April 2016 were also identified as a factor that discouraged service providers’ participation in the program. Some service providers who were deterred by the cuts to IFHP remained unaware of the program’s reinstatement. Others found themselves confused by the policy changes and preferred not to deal with IFHP, especially if they could get by with treating provincially-insured patients alone. The comments below from Participants S16 and S17 respectively spoke to these points:

“And there were so many different versions of [IFHP] ... that I think people, understandably, were not able to keep track of what was going on, and who was covered, and for what, which I think led to probably a number of providers deciding that they didn’t want to deal with IFH anymore.”

“The biggest issue we’re finding with IFH now is really a relic of what happened during those years where the program was cut. It’s that a lot of physicians actually opted out of seeing IFH patients. And for many of them they don’t recognize that the program has been restored. So, we’ve had many consultants who won’t take IFH today. And we’ve

had a few incidents where, you know, we've had people who've declined a request for consultation. Once we've contacted them, sent them the paperwork, referred them to the [government] website to let them know that the program has been restored, then they've decided to take it on. But I think there's still people who gave up on it and haven't come back on."

Additionally, some service providers considered IFHP's reimbursement process too complicated or the rate of reimbursement from IFHP too low to worth their effort. Participant S13's explanation for why she no longer took on IFHP patients in her dental clinic encapsulated this sentiment:

"[In the past,] where we actually do treatment and send for the billing and so on, we would get refusal of payment because the treatment is not covered [by IFHP], or other times, they would ask for more paperwork to be filed. ... I didn't have the time and my staff didn't have the time to follow through on this. It's quite a lot of paperwork, like we deal with insurance, but you also need to send X-rays, a letter and stating why you have to do this treatment. ... We do know the government insurance doesn't cover much. So, a lot of dentists are forced to not accept government insurance. ... That's not because they do not want to treat these patients. A lot of times they would treat these patients pro bono. But because, like I said, all the paperwork that the government insurance needs and at the end the minimum payment we would receive, I do not accept government insurance in my usual practice [anymore]."

3.5. Administrative Hurdles Facing IFHP Service Providers

As shown by Participant S13's comment immediately above, the administrative aspects of IFHP were another regular subject of complaint from our service provider interviewees (n=17). At the same time, these administrative requirements facing IFHP service providers were identified by some refugees and refugee claimants (n=6) as a cause of their negative experiences with the program.

The grumble from service provider participants touched on a range of IFHP's administrative processes, including provider registration with the program, verification of clients' IFHP eligibility at the point of service delivery, request for pre-authorization for certain services or products, and submission of claims for reimbursement. However, a vast majority of the complaints pertained to the last two of these processes.

3.5.1. Challenges Relating to Request for Pre-Authorization

Eight service providers described having encountered difficulty with IFHP's requirement that certain services or products must be pre-approved by Medavie Blue Cross before the costs would be covered. Harking back to the theme of IFHP illiteracy, some of them admitted to being initially unaware of the need to request pre-authorization in some circumstances, which left them uncompensated. Others pointed out that it was not always possible to seek IFHP approval before services were rendered, and this jeopardized their ability to get paid. By way of illustration, Participant S4, a dentist, observed:

"I will give a treatment plan for one tooth, and according to my diagnosis at the present time the X-ray showed me it is a two-surface restoration from the top and the side. The next tooth beside it I didn't call it because the X-ray did not reveal it at the time, me checking the X-ray. Now let's say clinically when I open that first surface, I see the

adjacent surface with my own eyes that it is decayed and I did not get it approved before. They will flatly refuse to pay it. So here, sometimes they are forcing our hand to over-diagnose to be on the safe side, but that also puts you in a highly ethical dilemma. What if you get in there and you over-diagnose that surface and call it a three surface but upon treatment you don't need it and you don't do it? And instead of submitting a three surface, you submit a two surface. Guess what? It gets denied.”

Another dentist, Participant S3, spoke of a similar challenge: “For complicated [tooth] extractions, they need pre-authorization. Sometimes when you get in there and [the extraction procedure] becomes complicated. Do I get paid?” He went on to complain about the amount of paperwork involved when submitting a pre-authorization request. And to the extent that such clerical tasks increased his overhead, he asked: “Why would I want to deal with that when I could deal with someone that pays up front?”

Another problem with the pre-authorization requirement, according to still other service providers, was the time it took for Medavie Blue Cross to process the requests. One pharmacist, Participant S8, described having to wait for “five to ten business days” to hear back from IFHP concerning whether a special authorization drug would be approved. Another pharmacist, Participant S11, however, found the response time concerning pre-authorization requests inconsistent. She noted:

“In some cases, I've had cancer medications that are thousands and thousands of dollars covered within days. And I've had something like stool softener for constipation that ... they take ten days to get back on. So, a little bit hit and miss.”

Inconsistencies notwithstanding, the possibility for pre-authorization to take time to be approved was confirmed by IFHP beneficiaries and a source of their complaint (n=5). Whereas one of these complaints concerned how certain medicine took “months” to be pre-authorized (Participant R21), the remainder all related to the amount of time it took for the requested dental services to be pre-approved. Participant R17, for instance, spoke about having to wait for six months to receive an approval for denture, which was necessary to replace his two missing front teeth. He said:

“I think it is excessive. It's like bureaucracy going on, and I don't think it's necessary. ... And it influences people, people's, you could say self-esteem, how people feel about themselves. ... It affects everyday life, because nobody wants to see, you know how it is. We all like to have pretty teeth. ... So, that's the dental part, which is like the worst from the worst from the worst.”

Likewise, Participant R16 talked about how his wife, who was also a refugee claimant, needed to make two trips to the dental office, incurring extra time and cost, to have two teeth extracted because pre-authorization was required for one of them. He stated:

“I felt like, if you are a dentist, and you see certain things, you should not have to go through another step to say, ‘okay, then I can get approval to move on’. Because ... from a medical standpoint, what could then happen is that small problem could escalate into something even worse. ... Because it was almost a month later that [my wife] had to go back [to] get the next extraction.”

3.5.2. Challenges Relating to Claim for Reimbursement

Nine service providers voiced challenges they had faced when seeking reimbursement from IFHP for services rendered. One element of the complaint, as mentioned above, concerned what some service providers (n=5) perceived to be an inadequate level of compensation from IFHP. For example, rightly or wrongly, as demonstrated earlier through Participant S13's comments, several dentists argued that the fee schedules adopted by IFHP, which were identical to those used by provinces and territories for their respective publicly-financed dental care programs, failed to cover their expenditure. This in turn disincentivized their participation in IFHP. As Participant S19 explained:

“I would say that in general, for dental clinics, they probably don't want to see [IFHP] patients. Because if [IFHP] is similar to ODSP, OW and what not, they really reimburse nothing. So, I guess it's not preferable for the business and just costs them money. ... If [IFHP has] better reimbursement, everyone would accept that. At the end of the day, it comes to that. With COVID and what not, the cost to run the clinic has increased and productivity has decreased. With government insurance, now people want to see them even less.”

Participants S13 and S19 also expressed frustration with having had some of their claims for reimbursement scrutinized by Medavie Blue Cross. In Participant S19's words, “sometimes they push back and question why we're doing this and why we billed that.” For him, the time and efforts required to resolve these billing issues, coupled with what he saw was an inadequate rate of compensation, caused him to conclude that it was too much trouble to take on IFHP clients, a sentiment shared by Participant S13.

In contrast, Participants S4, S5 and S6, who were also dentists, did not consider IFHP's fee schedule unreasonable. Nor did they question the necessity for IFHP to carefully evaluate each claim for reimbursement. Their billing-related complaint, instead, concerned the consistency and transparency of how reimbursement claims were approved or denied. For example, Participant S6 described the billing approval process under IFHP as “highly inconsistent.” Supposedly, it was possible for a claim for reimbursement that was initially denied by Medavie Blue Cross to be approved subsequently when the identical reimbursement request was resubmitted. This led him to conclude that the outcome of whether a reimbursement claim was approved or not “depend[ed] on who review[ed] it.” Participant S5 echoed this view and suggested that the seemingly arbitrary nature of the billing approval process was exacerbated by the fact that no explanation was provided to service providers when a request for reimbursement was denied.

Lastly, similar to what was said about the pre-authorization process, some service providers (n=5) found that it took too long for Medavie Blue Cross to reimburse them. However, given that most service providers interviewed in this study relied on administrative staff to deal with billing, the perception of IFHP's reimbursement process being cumbersome and slow was largely based on second-hand information. Participant S2's comments illustrated this point:

“Of course, the reimbursement, once it is submitted, it takes a long time. I don't have numbers. I don't do the billing, but this is what we are hearing from the community and our medical office assistant and how frustrating it is.”

As such, whether IFHP's reimbursement process was indeed slower than other health insurance programs would require further verification. This notwithstanding, it appeared that the impression of IFHP being slow with its reimbursement might have become accepted knowledge for some

service providers. Two of our refugee participants reported having been told by their health care providers about IFHP's slow billing process and how this made some reluctant to take on IFHP clients. For instance, Participant R18 noted:

“The doctor said [the reason why some placed would not accept IFHP is] because of the payments. ... I'm not sure, but it's not like OHIP. For IFHP, after six or seven months you can get payment, but it's easy to get payment from OHIP. Not IFHP.”

4. Conclusion

Despite the reinstatement of IFHP since April 2016, refugees and refugee claimants still face challenges when accessing health care services under the program. Some IFHP beneficiaries are unclear about the scope of their entitlement, which reduces their likelihood of seeking out certain health care services or products. When they do attempt to access health care, they learn that service providers are sometimes just as unfamiliar with IFHP as they are, and this in part causes some providers to not accept them as clients or to charge them additional fees that may or may not be legitimate. At times, their interactions with service providers are further clouded by language barriers, as well as service delay that is potentially related to administrative requirements that IFHP imposes on service providers. Together, these challenges impede refugees' and refugee claimants' health care access and lead some to feel mistreated because of their immigration status.

At the same time, service providers identify a number of factors that militate against their participation in IFHP. Some find the program and its recent policy history confusing. This is especially so if they seldom encounter refugee clients and only follow policy developments concerning IFHP periodically. Others argue that all service providers should be able to claim reimbursement from IFHP for services extended to beneficiaries, regardless of whether one has registered with the program. They see the registration requirement imposed by IFHP as a convenient way for some service providers to opt out of taking on IFHP patients. Still others are frustrated with billing-related matters under IFHP: the need to request pre-authorization for certain services or products is seen as cumbersome and not always feasible; the rate of reimbursement is considered too low by some; and both the pre-authorization and reimbursement processes are chided for being slow and unpredictable. Whether or not these assessments of IFHP are accurate, they risk becoming received wisdom among service providers and undermining service providers' willingness to work with IFHP.

Going forward, Canadian government must devote more attention to educating refugees, refugee claimants and service providers about IFHP and to answering their questions about the program. Such public education must be done in a way that is carefully tailored to the needs and circumstances of the specific audience. For example, when information about IFHP is communicated to refugees and refugee claimants, it should be translated/interpreted and laid out in plain language. As much as it is important to inform beneficiaries and providers the services or products covered by IFHP, it would be equally helpful to have the differences in coverage between IFHP and other publicly-funded health insurance programs clearly explained. Moreover, to the extent that service providers' negative perceptions about IFHP are inaccurate, it would be critical for the government to counter these myths with facts. Alternatively, if complaints about IFHP's billing and coverage gaps are on point, their timely resolution by government will be key to ensuring that IFHP accomplishes the objectives of protecting refugees' and refugee claimants' health and safety.