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REFERENCE

1. Winston S. Churchill. Speech at Harvard University. September 6, 1943.

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The Society of Obstetricians and Gynaecologists of Canada's Position Statement on Federal Budget Cuts to the Interim Federal Health Program

To the Editor:

The Canadian government's decision to curtail the scope of the Interim Federal Health Program (IFHP), which provides temporary health care coverage to refugees and refugee claimants, has generated diverging views on how refugee women will likely fare following the policy change. Whereas the Society of Obstetricians and Gynaecologists of Canada is satisfied that "refugee claimants will continue to have access to the obstetric and gynaecologic services they require,"[1] an open letter from eight other health care professional associations suggests that the IFHP cuts may undermine the health of refugees who are pregnant.[2]

The seeming optimism of the SOGC is problematic on at least three grounds.

First, the SOGC has failed to fully appreciate the access barriers confronting female refugees who will only be granted so-called "public health or public safety health care coverage" under the new program. Claimants from designated "safe" countries and unsuccessful refugee applicants will receive no health care unless there are public health or public safety concerns. Women who fall within this category will have no access to publicly funded obstetric and gynaecologic services, even in emergency, except treatments for STIs and HIV/AIDS.

Studies demonstrate that pregnant women without health care coverage tend to lack adequate prenatal care, and have elevated risks of experiencing premature births and perinatal mortality.[3] As such, IFHP cuts are prima facie contrary to international law, which safeguards everyone's right to health.[4] At a minimum, international human rights standards entitle "[a]11 persons, irrespective of their nationality, residency or immigration status" to primary and emergency medical care.[5]

Second, the SOGC has shown insufficient concern for the fact that, under the new IFHP, all refugee claimants will lose prescription drug coverage except for medications required to alleviate public health or public safety concerns. In the reproductive and sexual health context, this benefit reduction can adversely affect female claimants who are pregnant and living with chronic conditions such as diabetes, as they will face greater obstacles obtaining essential medications for ensuring a safe pregnancy. Moreover, contrary to evidence-based clinical guidelines,[6] both contraceptives and family planning counselling will no longer be covered.

The SOGC trivialized this benefit cut by suggesting that it merely ensures that the breadth of health services received by refugee claimants is on a par with that received by Canadians. This simplistic comparison ignores the extraordinary circumstances asylum-seekers often find themselves in, which heighten their health needs while limiting their ability to access care privately. The SOGC's reasoning also violates international law, which mandates governments to allocate the maximum amount of available resources to pregnancy-related care and to provide free services where necessary.[7] Indeed, the level of drug benefits formerly enjoyed by refugees was in line with what many marginalized Canadians receive through provincial social assistance programs.

Third, the SOGC's emphasis on all refugee claimants continuing to receive an immigration medical examination (IME), which supposedly includes a comprehensive well-woman consultation, is inconsistent with many refugees' lived experiences. For example, research on the HIV testing aspect of the IME has revealed significant inadequacies when compared with guidelines established by the WHO and UNAIDS.[8] One should therefore be cautious not to equate the IME with health coverage that ensures refugees' timely and regular access to preventive and primary care.

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REFERENCES

1. Society of Obstetricians and Gynaecologists of Canada. Position statement: federal budget cuts to the Interim Federal Health Program; 4 June 2012. Available at: http://www.sogc.org/documents/medRefugeeHealthBenefitsStatementENG120604.pdf. Accessed July 19, 2012.

2. Joint letter to the Minister of Citizenship and Immigration, the Hon. Jason Kenney, from Canadian Association of Optometrists, Canadian Association of Social Workers, Canadian Dental Association, Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, College of Family Physicians of Canada, and The Royal College of Physicians and Surgeons of Canada, 18 May 2012.

3. Caulford P, Yasmin V. Providing health care to medically uninsured immigrants and refugees. CMAJ 2006; 174:1253–4.

4. Office of the United Nations High Commissioner for Human Rights. International Covenant on Economic, Social and Cultural Rights; December 16,1966: 993 U.N.T.S. 3, art. 12.

5. United Nations Economic and Social Council Official Record. General Comment No. 19: The right to social security (Art. 9 of the Covenant), UN ESCOR, 39th Sess., UN Doc. E/C.12/GC/19 (2008) at para. 37.

6. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011; 183:E824–E925.

7. CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), CEDAW, 20th Sess., UN Doc. A/54/38/Rev.1, chap. I (1999) at para. 27; Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 U.N.T.S. 14, art. 12(2).

8. Bisaillon L. Mandatory HIV screening policy and everyday life: a look inside the Canadian immigration medical examination. Aporia 2011; 3:5–14; 15:84–6; WHO & UNAIDS. Guidance on provider-initiated HIV testing and counselling in health facilities, May 2007.

The Society of Obstetricians and Gynaecologists of Canada's Position Statement on Federal Budget Cuts to the Interim Federal Health Program

To the Editor:

On June 4, 2012, the Society of Obstetricians and Gynaecologists of Canada published a position statement on cuts to the Interim Federal Health Program[1] that declared "We are pleased that refugee claimants will continue to have access to the obstetric and gynaecologic services they require."

In stark contrast, health organizations including the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Association of Optometrists, the Canadian Association of Social Workers, the Canadian Dental Association, the Canadian Medical Association, the Canadian Nurses Association, the Canadian Pharmacists Association, and the Canadian Association of Midwives called for rescinding of these cuts.[2] Even Citizenship and Immigration Canada's Director General of Health, Dr Danielle Grondin, could not call this a good health decision.[3]

The SOGC mission is "to advance the health of women through leadership, advocacy, collaboration, outreach, and education." Sadly, here it fails on all counts. Apparently there was no outreach to those caring for refugees, and no collaboration with the organizations above. Advocacy and leadership through this statement excluded the most vulnerable among us, often those who came seeking refuge from horrific conditions, without the supports and capacities of most Canadians, and public education with this press release was based on inaccurate information in terms of who was covered for what conditions.

The statement claims that "[a]11 prenatal, delivery and postpartum health services" will continue to be covered, later qualifying this to note that it might be untrue for "a select few refugee claimants based on their designated country of origin." According to Citizenship and Immigration Canada, obstetrical services available to those from designated country of origin (DCO) countries are, literally, none.[4] "Urgent or essential gynaecologic services" are not covered for DCO women, unless the conditions needing treatment, possibly including STIs but excluding mental health services such as counselling for rape victims or even suicidal ideation, become an issue for public health or safety.

Coverage for medication for all refugees, including invited government-assisted refugees, was eliminated. Having cared for hundreds of refugee women, I can assure you that such women couldn't afford supplies to manage their diabetes in pregnancy. Ironically, if an Iraqi refugee had remained in temporary housing in Jordan, such medication would have been a fraction of the price in Canada, and had the Congolese woman remained in a refugee camp an international non-governmental organization would have provided her drugs. Providing comfort to claimants, the statement advises "alternate avenues for service exist and . . . products such as contraception may be accessible to them via compassionate programs."[1] How will this be communicated to refugees, by whom, and in what language?

"In conclusion, the SOGC recognizes that spending from the public purse in support of health services is reaching crisis proportions. . . . products and services must be dispensed in a fair and equitable manner. . . ."[1] Is leaving the pregnant woman with untreated hypertension to deliver a premature Canadian baby good crisis management? Will costs merely be offloaded to the provinces? Is this "fair and equitable?" Refugees are initially ineligible to receive social assistance, which covers all medication and services provided by IFHP.

Some would say that the government's decision appears to be based more on ideology than on evidence. Popular pressure from other medical organizations forced a tacit reversal regarding government assisted refugees on the eve of the implementation.[5] Which leads to the question: what prompted the SOGC statement?