Cuts to supplemental health benefits for refugees: Expanding the understanding of patient-centred care

IN APRIL 2012, THE MINISTER OF CITIZENSHIP, IMMIGRATION AND Multiculturalism, Jason Kenney, unexpectedly announced that the federal government would no longer provide supplemental health benefits for refugees under the Interim Federal Health Program, a post-war program that had been established in 1957 to provide refugees with access to services such as dental care, vision care and medications. The Minister's rationale for eliminating supplemental health benefits was twofold: one, the \$84 million was needed to help reduce the federal deficit, and two, refugees should not receive better public health benefits than Canadians.

On the heels of this announcement, CPhA assembled a coalition of 8 other national health provider organizations, including the Canadian Medical Association, the Canadian Dental Association and the Canadian Nurses Association, in opposing this policy move. The coalition sent a strongly worded letter to the Minister in May 2012 outlining the negative implications of this change, and refuted the proposition that this announcement would result in cost savings to the taxpayer, given that other public bodies would ultimately be forced to absorb the costs of care. CPhA also spoke out loudly in the media against this change. The efforts on the part of the national provider groups were bolstered by advocacy efforts on the part of individual physicians and health care providers who targeted government politicians over the early summer, demanding answers as to why the federal government was abandoning this vulnerable population. These efforts culminated in a national Day of Action on June 18, when rallies (including a large one on Parliament Hill) were held across the country to protest this change.

Our actions have had partial success. Immediately before the change was to go into effect July 1, the federal government partially backtracked by clarifying that refugees who fell under the "Resettlement Assistance Program" or its Quebec equivalent would remain eligible for supplemental health benefits — it is estimated that this category includes approximately one-third

of all refugees in Canada. However, other refugees in Canada remain without any form of supplemental health benefits whatsoever, and therefore efforts to advocate on their behalf for reinstatement of supplemental health benefits will continue. (A breakdown of the benefits available to each classification of refugee is available on the Citizenship and Immigration Canada website¹ or the CPhA website²).

Given CPhA's leadership role in responding to this announcement, several pharmacists have asked a simple question — Why? With many other advocacy priorities that CPhA is actively pursuing, why take up this particular cause? The answer to that question goes to the very heart of the vision that CPhA and the Blueprint for Pharmacy have laid out: an

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evolution on the part of the pharmacist towards greater patient-centred care. For many pharmacists, the term "patient-centred care" may be seen strictly as providing enhanced medication management services for patients — in other words, focusing proper care on the individual patient. However, patient-centred care can, and arguably should, be viewed from a wider perspective. Patient-centred care should also extend to advocating on behalf of the patient — ensuring that systems, regulations and policies are in place that will protect the health and well-being of patients at a collective level, regardless of whether those regulations have a direct impact on the pharmacy profession or not.

Physicians have a long history of advocating for better patient-centred care at a systems level. Organizations such as the Canadian Medical Association have taken strong positions on a broad array of issues that do not directly impact upon medical practitioners, but have a direct bearing on the health and well-being of patients — for example, their most recent Annual Congress in August 2012 was devoted in large measure to social determinants of health and the impact of income on health outcomes. Given pharmacists' history in medication management, and their day-to-day expertise in improving the health of patients, pharmacists and CPhA, in particular, can play a key role

in advocating for better health policies and systems.

From this perspective, CPhA's advocacy efforts to reinstate supplemental health benefits for refugees, who are undeniably some of our country's most vulnerable and disadvantaged members, can be viewed as a prime example of advocating on behalf of the interests of patients. As the Blueprint vision becomes more widely integrated into pharmacy practice and culture, we hope that the pharmacy community will embrace the notion of advocating not just on behalf of their profession, but for policies and programs that enhance the health outcomes of their patients. CPhA's efforts to protect refugee health are just one of the first steps to come in that direction. ■

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