

IMPACTS OF THE IFHP ON HEALTHCARE ACCESS & PROVISION, CANADA

IMPACTS OF THE INTERIM FEDERAL HEALTH PROGRAM ON HEALTHCARE
ACCESS AND PROVISION FOR REFUGEES AND REFUGEE CLAIMANTS IN CANADA:
A STAKEHOLDER ANALYSIS

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements
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TITLE: Impacts of the Interim Federal Health Program on healthcare access and provision for
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ABSTRACT

Background: Refugees and refugee claimants experience health needs upon arrival in Canada. Retrenchments to the Interim Federal Health program (IFHP) in 2012 greatly reduced healthcare access for refugee claimants, generating concerns among healthcare providers and other stakeholders affected by the reforms. In 2014 a new IFH program temporarily reinstated access to some health services however, little is known about the reforms and more information is needed to map its impact on key stakeholders. This study aims to examine the perception of key stakeholders regarding the impact of the 2014 reforms on the policy's intermediary goals: access and provision of healthcare.

Methodology: Data was collected using semi-structured key informant interviews with refugee health policy stakeholders (n=23), refugees and refugee claimants (n=6), policy makers and government officials (n=5), civil society organizations (n=6) and professionals and practitioners (n=6). Data was analysed using a constant comparative approach with NVivo 10 (QSR International). A stakeholder analysis was used to map out key stakeholder perceptions, interests and influences in refugee health policy and a content analysis was further employed to abstract themes associated with barriers and facilitators to access and provision of healthcare in the current situation.

Results: The findings provide information for management of stakeholder engagement revealing the perceptions of key stakeholders on the 2014 reforms: eight were opposed to the reforms, eight held mixed positions, four supported the reforms and one did not comment. Five facilitators to accessing healthcare were identified. Eighteen themes emerged under four health care access

and provision barrier categories: cognitive, socio-political, structural and financial. There were four common themes perceived among all stakeholder groups: lack of communication and awareness of refugee and provider, lack of care provider training leading to unfamiliarity with IFHP, lack of continuity and comprehensive care and the political discourse leading to refugee and claimant social exclusion. Other common barrier themes included healthcare affordability for refugees and the healthcare system, fear of the healthcare system, and interaction with the Ontario Temporary Health Program.

Conclusion: The study highlights that reforms to the IFHP in 2014 have transferred refugee health responsibility to provincial authorities and healthcare institutions resulting in bureaucratic strains, inefficiencies, overburdened administration and increased health outcome disparities as refugees and claimants choose to delay seeking healthcare due to existing barriers. There are some benefits to the reforms, but the lack of support and mixed opinions among the majority of stakeholders emphasize the need for reformulation of policy with stakeholder engagement. This study recommends future refugee health reform strategies incorporate stakeholder leadership, cooperation and perspectives, as revealed in this research, to successfully move healthcare policy from theory to practice.

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TABLE OF CONTENTS

ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	v
TABLE OF CONTENTS	vii
LIST OF TABLES AND FIGURES.....	xii
LIST OF ABBREVIATIONS.....	xiii
DECLARATION OF ACADEMIC ACHIEVEMENT	xv
CHAPTER ONE: INTRODUCTION.....	1
CHAPTER TWO: BACKGROUD.....	5
Globalization of refugee movements and the state's sovereign response.....	5
1.1 Forced Migration.....	5
1.2 The Sovereign Response.....	6
The Canadian Context.....	7
2.1 History and definitions.....	7
2.2 Immigration and Protection Act & Safe Third Country Agreement.....	9
2.3 Refugee determination process and precarious legal status.....	11
The impact of Bill C-31 on refugee claimants.....	13
CHAPTER THREE: INTERIM FEDERAL HEALTH PROGRAM.....	16
IFHP 2012 legislative changes	16
Reaction to the 2012 reforms	18
2.1 Argument against objective one: Temporary Program.....	20
2.2 Argument against objective two: Fairness to Canadians.....	21

2.3 Argument against objective three: Protecting the Public.....	23
2.4 Argument against objective four: Defending the System.....	23
2.5 Argument against objective five: Containing the Cost.....	24
Introduction of the new IFHP 2014 reforms	26
Rationale	28
Key Stakeholders.....	29
CHAPTER FOUR: STUDY METHODOLOGY.....	37
Study Design.....	37
1.1 Design and Stakeholder Perspectives.....	37
1.2 Objectives and Research Questions.....	38
Study Procedures.....	39
2.1 Approval, Consent and Confidentiality.....	39
2.2 Identification of Stakeholder Categories.....	40
2.3 Recruitment and Sampling.....	42
2.4 Limitations.....	43
Data Collection.....	43
3.1 Qualitative Approach and Interviews.....	43
3.2 Sample Size and Study Population.....	45
Data Analysis.....	46
4.1 Literature Review and Inductive Content Analysis.....	46
4.2 Open-coding and Coding with NVivo 10.....	47
4.3 Abstraction of Themes.....	48
4.4 Stakeholder Analysis.....	49
4.5 Quality and Trustworthiness.....	49
4.6 Limitations.....	50
CHAPTER FIVE: FINDINGS.....	52

Introduction.....	52
Demographic Profile of Key Stakeholders.....	53
Policy Makers and Government Officials.....	54
3.1 Involvement of Policy Makers and Government Officials.....	54
3.2 Position of policy makers and government officials.....	55
Civil Society Organizations.....	57
4.1 Involvement of Civil Society Organizations.....	57
4.2 Position of Civil Society Organizations.....	59
Professionals and Practitioners.....	62
5.1 Involvement of Professionals and Practitioners.....	62
5.2 Position of Professionals and Practitioners.....	63
Refugees and Refugee Claimants.....	65
6.1 Profile of Refugee and Refugee Claimant stakeholders.....	65
6.2 Position of Refugees and Refugee Claimants.....	66
CHAPTER SIX: FINDINGS PART 2.....	69
Introduction.....	69
The IFHP 2014 reforms.....	70
2.1 Benefits: What works?	70
2.2 Disadvantages and Barriers.....	74
Barriers Perceived by Policy Makers and Government Officials.....	77
Barriers Perceived by Civil Society Organizations.....	87
Barriers Perceived by Professionals and Practitioners.....	104
Barriers Perceived by Refugees and Refugee Claimants.....	115
The Ontario Temporary Health Program.....	125
7.1 Policy Makers and Government Officials.....	125

7.2 Civil Society Organizations.....	127
7.3 Professionals and Practitioners.....	128
Facilitators.....	130
CHAPTER SEVEN: DISCUSSION.....	138
Introduction.....	138
Summary of Findings Part One.....	138
Summary of Findings Part Two.....	143
3.1 Similarities and Differences.....	145
Conclusion: Summary of Results.....	152
Relationship of findings with the literature and further insights.....	154
5.1 Policy Adoption.....	154
5.2 Policy Implementation.....	161
CHAPTER EIGHT: CONCLUSION AND RECOMMENDATIONS.....	164
Conclusion.....	164
Stakeholder Recommendations.....	165
Study Recommendations.....	168
References.....	170
Appendices.....	187
A: Flowchart of "Temporary Measures of the IFHP".....	187
B: Letter of Research Ethics Approval.....	188
C: Participant Consent Form.....	190
D: General Stakeholder Interview Guide	194

E: Refugee and Refugee Claimant Interview Guide.....	196
F: Recruitment Email.....	197

LIST OF TABLES AND FIGURES

TABLE	Page
Table 1. Work Experience of Key Stakeholders and Lived Experience of Refugee and Refugee Claimant Stakeholders.	53
Table 2. Policy maker and Government official Characteristics	57
Table 3. Civil Society Organization Stakeholder Characteristics.....	61
Table 4. Professional and Practitioner Stakeholder Characteristics.	65
Table 5. Refugee and Refugee Claimant Stakeholder Characteristics	68
Table 6. Healthcare access barriers and corresponding barrier dimensions	76
Table 7. Similarities among all stakeholder perspectives	145
Table 8. Differences among stakeholder perspectives regarding healthcare barriers	149
 FIGURE	
Figure 1. Stages of the Policy Cycle	2
Figure 2. Logic Model of the IFHP 2014 reforms	38
Figure 3. Healthcare access and provision barrier model	75
Figure 4. Stakeholder Map: Positions vs. Influence	142

LIST OF ABBREVIATIONS

BOC	Basis Of Claim
CARL	Canadian Association for Refugee Lawyers
CBO	Community-based Organization
CDRC	Canadian Doctors for Refugee Care
CHC	Community Health Centre
CIC	Citizenship and Immigration, Canada
CMAJ	Canadian Medical Association Journal
CPhA	Canadian Pharmacists Association
CSO	Civil Society Organization
DCO	Designated Country of Origin
ED	Emergency Department
EHCC	Expanded Health Care Coverage
GAR	Government-assisted refugee
H & C	Humanitarian and Compassionate
HCC	Health Care Coverage
ICAP	In-Canada Asylum Program
IFHP	Interim Federal Health Program
IMF	International Monetary Fund
IPRA	Immigration and Protection Act
IRB	Immigration and Refugee Board
LMIC	Low or Middle Income Country
Non-DCO	Non-Designated Country of Origin
OIC	Order In Council
OTHP	Ontario Temporary Health Program
PG	Policy Maker and/or Government Official
PHPS	Public Health and Public Safety
PP	Professional and/ or Practitioner
PSR	Privately sponsored refugee
RAD	Refugee Appeal Division

RAP	Resettlement Assistance Program
RRC	Refugee or Refugee Claimant
RHRP	Refugee and Humanitarian Resettlement Program
RPD	Refugee Protection Division
STCA	Safe Third Country Agreement
UNHCR	United Nations High Commissioner for Refugees
USCRI	United States Committee for Refugees and Immigrants
WHO	World Health Organization

DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration that the content of the research in this document has been completed by Valentina Antonipillai and recognizes the contributions of Dr. Andrea Baumann, Dr. Andrea Hunter, and Dr. Timothy O'Shea in both the research process and the completion of the thesis.

CHAPTER 1

INTRODUCTION

Policies are governmental responses to the interaction of social, economic, political and cultural factors within a problem area. There are several concerns associated with providing refugees healthcare in Canada. The refugee healthcare domain remains an inherently complex issue spanning across various sectors and impacting numerous groups and organizations interested in reducing refugee health outcome disparities. The Interim Federal Health Program (IFHP) policy is the refugee health policy in Canada established in 1957, aimed at promoting the health and well-being of asylum seekers and refugees. The program is intended to provide, “emergency and essential health coverage” before refugees are considered permanent residents and become eligible for provincial health insurance (Government of Canada, 2006). Therefore, the IFHP can be considered a 'healthy policy', which "improves the conditions under which people live: secure, safe, adequate and sustainable livelihoods, lifestyles and environments, including . . . necessary community and personal social and health services" (Milio, 2001, p. 622). The IFHP provides necessary health insurance to improve the livelihoods of countless refugees and refugee claimants. Ultimately, its expected impact on health depends on its provision of access to adequate healthcare services.

The IFHP is a publically funded program delivered by Citizenship and Immigration Canada and implemented by various other sectors. Thus, governments are not the only actors involved in the development and implementation of healthy policy. Groups and individuals who affect or are affected by a policy, known as stakeholders, can influence any point of the policy cycle from setting the agenda to implementing and evaluating results. Policy makers at each stage of the policy process (see Figure 1) need to decide when and how to involve stakeholders

as well as which ways to manage stakeholder relationships (Steincke et al., 2012). Research on stakeholder engagement in both the public and private sectors has identified several benefits for policy makers. Firstly, groups and individuals affected by an issue possess critical insight that brings information into the deliberation process such that decisions made are more likely to avoid unintended consequences and fit into existing policy contexts. If stakeholder groups disagree with policy goals, successful implementation of policy is made more difficult (Garn, 1999). Particularly, a specific policy direction may revert from its original purpose due to the involvement of certain stakeholders with opposing views (Horev & Babad, 2005). As a result, cooperation and leadership from various stakeholders are needed in order to implement healthcare reform and move theory into practice (Canadian Healthcare Association, 2001; Segal, 2000).

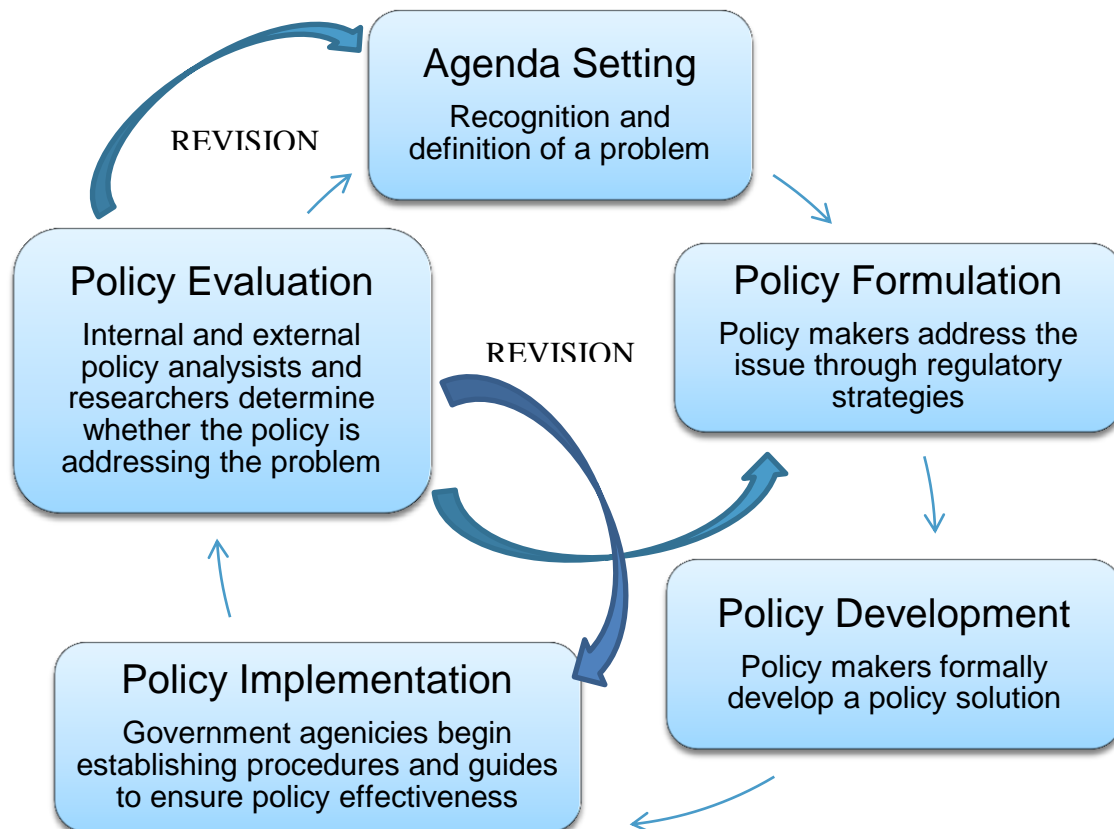


Figure 1. Stages of the Policy Cycle: Adopted from Werner and Wegrich (2007)

In 2012, healthcare coverage under the IFHP was substantially reduced for refugees and refugee claimants, limiting their access to preventative and primary care. Moreover, the provision of tiered levels of healthcare coverage, depending on immigration status and country of origin, eliminated access to emergency services for some categories of these vulnerable individuals (Government of Canada CIC, 2012c). The 2012 retrenchments to the IFHP led to an unprecedented response from Canadian healthcare providers, professionals and organizations. Nation-wide protests, letters to the Minister expressing opposition to the cuts, and a legal challenge launched by these stakeholders resulted in the revision of the cuts to refugee health policy (Jones, 2013; Keung, 2012; Sanders, 2012). In an unprecedented decision, the federal court found the reductions to refugee health care constituted “cruel and unusual” treatment, violating section 12 of the Charter of Rights and Freedoms, Citizenship and Immigration Canada reinstated access to some healthcare services for refugees and refugee claimants in 2014 (CDRC v. AGC, 2014; Government of Canada, CIC, 2014b).

The objective of this research is to examine the perceptions of key stakeholders and effectiveness of the reforms made to the Interim Federal Health program 'healthy policy' in 2014. A literature review provided the necessary background for design of the study and offered insight on the social, economic, political and cultural context surrounding the Interim Federal Health Program (IFHP). This review reinforced the need to address knowledge gaps regarding the effectiveness of the program following regulatory changes in 2014. Using key informant interviews with stakeholders, including policy-makers and government officials, civil society organizations, professionals and practitioners as well as refugees and refugee claimants, a stakeholder analysis provides insight on their positions, interests and influences to assess acceptability of the policy reforms. Furthermore, the stakeholder analysis provides knowledge on

the barriers and facilitators of accessing and providing healthcare under the current program.

This provides an opportunity to assess whether the policy achieves its intermediate goals of enabling access and provision of healthcare for the refugee and claimant population in Canada through the perceptions of key stakeholders. Themes are abstracted, with recommendations drawn to provide directions for further research and policy-making in Canadian refugee health.

CHAPTER 2

BACKGROUND: CANADIAN REFUGEE POLICY

Globalization of refugee movements and the state's sovereign response

1.1 Forced Migration

Forced migration is growing in volume and significance because of endemic violence and human rights violations. One of the fundamental causes for increased refugee mobility derives from the amplified number of conflicts that are becoming more protracted and persisting for decades (UN, 2012). Countries such as Syria, Somalia, Afghanistan, Congo and Sudan exhibit ongoing conflicts with little prospects of an end. As a result, these countries produce mass outflows of individuals seeking a safe haven for their well-being and that of their families (UNHCR, 2014, p. 5). The global refugee population grew from 2.4 million in 1975 to 10.4 million in 2003 (UNHCR, 2003). Currently the UNHCR reports that there are 16.7 million refugees of the 51.2 million forcibly displaced migrants, worldwide (UNHCR, 2014). These rising numbers of displaced persons forced to migrate from their country of origin has stimulated a feeling of "compassion fatigue" among high income nations (Dowty & Loescher, 1996, p.62). These nation-states have become too overwhelmed to view refugees as dispossessed vulnerable individuals in need of protection, and are more inclined to interpret mass movements of asylum-seekers as a collective aimed at undermining state borders and depleting state resources (Dowty & Loescher, 1996).

However, the US committee for Refugees and Immigrants (USCRI) revealed that countries with per capita incomes of over \$10,000 USD host only 5% of the world's refugees (USCRI, 2007, p.13). Whereas countries like Pakistan alone hosted more refugees than many developed nations, such as Canada, France, Australia, US, Germany and Sweden combined. By

the end of 2013, Pakistan continued to host the largest number of refugees in the world totaling an amount of 1.6 million refugees. This number of refugees assisted in Pakistan is nearly equivalent to the total number of refugees residing in every nation of the entire European continent (UNHCR, 2014). The top nine refugee hosting countries consist only of low and middle income countries (LMICs) including Turkey, Ethiopia and China. Together these nations hosted approximately 64% of all displaced refugees worldwide (UNHCR, 2014). Thus, statewide restrictions imposed by Western nations to prevent the increased flow of refugees cannot be entirely attributed to 'fatigue' caused by providing an 'overwhelming' amount of humanitarian assistance as these nations harbor only a minute fraction of the total refugee population. In fact, poorer countries are already bearing the greatest cost by accepting the majority of refugees to the detriment of their own resources and economies. As a result, Western countries may be raising concerns about the rise of refugee numbers worldwide because the international community may subsequently turn to wealthier nations to pay the large cost for humanitarian relief and assistance

1.2 The Sovereign Response

In modern times, sovereignty is power or authority expressed by the state and is represented by the existence of a political community with a shared notion of national identity. According to Nyers, state sovereignty must be understood as a historical and 'performative' practice that is constantly changing. It is an ongoing practice in which the establishment of a sovereign political community and its respective citizenship is not only found in the nation's past, but, "the distinctiveness of every polity has to be re-established [in the present] to reaffirm allegiance and loyalty to its citizen population" (Nyers, 2006, p. 27). While the people have not always served as the foundation for state sovereignty, the members of state or citizens who constituted the nation in the past and present have participated in the sovereignty of the state and

constructed its current national identity. As a result, state sovereignty and national identity become threatened when there are no clear standards that determine who constitutes the nation. If the criteria for differentiating the inside of the state, comprising of its citizens, from the outside are ambiguous, the line defining the borders of the state and its sovereignty become faded (Doty, 1996). Thus, the right of entry into a state is a crucial part of state sovereignty, particularly in the contemporary context of globalization and mass movements of refugees.

The threat of an increased influx of refugees into the state is accompanied by state concerns of increased cultural and political disruptions that challenge the identity of the state and erode the nation-state's sovereignty (Mandel, 1997). As refugees maintain the right to seek asylum in industrialized countries, tensions between state sovereignty and humanitarian legal obligations of the host state arise. To maintain the current state sovereignty, nations implement domestic policies that attempt to differentiate between migrants, enabling the selection of highly skilled migrants who would contribute to the growth of the economy, and the restriction of refugees, unskilled migrants and their families, all of who may pose an economic burden and political threat to the sovereign host nation (Basok, 1996). As Loescher reaffirms, "the formulation of refugee policy involves a complex interplay of domestic and international factors at the policy-making level and illustrated conflict between international humanitarian norms and the sometimes narrow self-interest calculations of sovereign nation-states" (Loescher, 1989, p. 8). As a result, the state implements national immigration and refugee policies which aim to protect state sovereignty and exclude certain migrants, such as refugee claimants, by distinguishing the identity of refugee claimants from that of the nation.

The Canadian Context

2.1 History and definitions

Canada as a political entity or sovereign state expresses its national identity through solidarity based on formal recognition of the Canadian citizen. The establishment of Canadian national identity includes assigning its citizens a place in the political community to participate in the control of the state and its sovereignty (Doty, 1996). Therefore, the nation-state, in the interests of the civil society, may exercise control over its borders through the formation and implementation of refugee and immigration determination policies. Refugees and refugee claimants exist outside of this institutionally protected and governed civil society, as non-citizens constrained by the practices and policies for their resettlement.

Throughout history, Canadian national identity has been founded on notions of humanitarianism and equity for all, by wholeheartedly welcoming refugees into the country (Dauvergne, 2012). As a signatory to the 1951 UN Convention, the 1966 International Covenant on Civil and Political Rights and the 1967 Protocol on Refugees, Canada, assumed its legal obligation to grant protection to Convention Refugees and persons in need of protection. However, before an individual claiming refugee status is approved as a Convention refugee or person in need of protection, their claims must be assessed through the refugee determination process. In Canada, individuals are recognized as refugees out of the country and provided with permanent landed residency upon arrival if they are recognized according to the 1951 Convention as:

A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, due to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country where he/she normally lives, is

unable or, due to such fear, is unwilling to return to it. (Citizenship and Immigration Canada, 2015)

The UNHCR indicates that an asylum seeker, or refugee claimant, is an in-land refugee applicant whose claim has yet to be determined. Thus, in-land claimants have temporary status and only receive protection if they are found to be a Convention refugee according 1951 UN Convention definition or found to be a Person in Need of Protection:

A person whose removal to his/her country of origin would subject them personally to the danger of torture; a risk to life, or; a risk of cruel or unusual treatment or punishment. (UNHCR, 2010)

A federal court decision in 1985 (Singh vs. Minister of Employment and Immigration. 1 S. C. R. 177) created a refugee determination system that allowed refugee claimants to represent their case on an individual basis to a government official promoting a more nuanced decision-making process to integrate refugees into Canadian society (Manjikian, 2013). In 1986, Canada was awarded the Nansen medal for its context-specific refugee determination approach and applauded for its efforts to assist refugees in becoming permanent, contributing members of Canadian society (Dauvergne, 2012).

2.2 Immigration and Protection Act & Safe Third Country Agreement

The construction of Canada's nation-building self-image began to deteriorate during the onset of the 21st century by promoting exclusive policies with the introduction of Canada's Immigration and Protection Act (IPRA) in 2002. While maintaining the previous emphasis on economic and humanitarian criteria for immigrant selection, the 2002 IPRA implemented the Safe Third Country Agreement (STCA) in 2004. The STCA was brought about as an agreement between the Canadian and American governments for cooperation in the examination of refugee

status claims from nationals of third countries. This agreement allowed government officials to return any refugee claimant, "who arrive[d] in Canada via a third country in which a safe haven could have been sought" without a hearing (Basok, 1996, p. 142). Therefore, the Safe Third Country Agreement was a measure employed by the Canadian state to intercept potential refugee claimants before their arrival to state borders in an attempt to make a claim.

Under the 2002 IPRA, refugee claimants are provided with two avenues to receive protection: The Refugee and Humanitarian Resettlement Program (RHRP) and the In-Canada Asylum Program (ICAP). Through the RHRP and the Private Sponsorship for Refugees Program, government-assisted refugees (GAR) and privately-sponsored refugees (PSRs) either arrive as permanent residents to Canada from overseas or become permanent residents after a brief waiting period in Canada (Manjikian, 2013; Goldring, Berinstein, & Bernhard, 2009). In 2013, the Canadian government resettled 5,756 GARs and 6,277 PSRs (CIC, annual report). The ICAP however, allows asylum-seekers to make a claim for refugee status from within the country at Citizenship and Immigration Canada (CIC) offices or at any Canadian border. Claimants who apply for refugee status inland must wait several months to be deemed eligible by the CIC (Goldring, Berinstein, & Bernhard, 2009). This waiting period can last years and promotes the persistence of a precarious legal status in which refugee claimants are restricted from certain provisions and entitlements that are available for those with permanent status or citizenship. According to the CIC, Canada received new in-land asylum applications from 10,380 claimants in 2013 (CIC, 2014). How many of these claimants were resettled is unknown, however, with a 38% asylum claim acceptance rate in Canada, only 3945 claimants would succeed in obtaining permanent status as a refugee (AMSSA, 2013). This number of claimants

approved accounts for almost 50% less than the admitted number of PSRs and GARs each that same year.

Furthermore, refugee claimants do not receive any financial assistance for resettlement and solely receive protection of a safe country while waiting on the decision for their claim to permanently reside in the country, if they qualify as a person in need of protection. On the other hand, the RHRP provides Resettlement Assistance Programs (RAPs) for GARs and PSRs, who are bestowed with financial assistance in the form of income either from the Canadian government or from a private sponsor, respectively. These Convention refugees are also entitled to other settlement services such as assistance to find permanent housing (CIC, 2014a). While refugee claimants are eligible to apply for social assistance on their own, they remain ineligible for settlement and integration services until the approval of their claim for permanent refugee status (Kisoon, 2010).

2.3 Refugee determination process and precarious legal status

The fulfillment of eligibility criteria is required by the CIC for the claimant to submit an application to the IRB for refugee status. Claims are ineligible if the person made a previous claim in Canada, if the person has refugee status in another country, if the person is barred under the Safe Third Country Agreement, or if the person is inadmissible on security or certain criminality grounds (Government of Canada CIC, 2012a). On the occasion the claimant passes the eligibility criteria, the application is reviewed by the Immigration and Refugee Board (IRB) and referred to the Refugee Protection Division (RPD) through which eligible refugee claimants are entitled to hearings before RPD members. The purpose of the hearing is to determine whether claimants meet the definition of a "Convention refugee" or "person in need of protection." According to Herlihy and Turner (2007), refugee determination is a highly complicated

processes due to the lack of objective evidence available to boards to make an informed decision, the inconsistencies in the applications of justice amongst refugee decision-makers and arbitrary refugee policies in place. Thus, the refugee determination process takes in-land claimants through a complex and prolonged infrastructure, assigning a precarious legal status to individuals seeking asylum (Goldring, Berinstein, & Bernhard, 2009).

According to Goldring et al. (2009, p. 245), "The concept of precarious status reflects insecurities associated with policies designed to control immigration and curb the overall number of permanent immigrants on the part of states . . . and the tendency to make citizens increasingly individually responsible of their existence . . . reducing the welfare state and social citizenship." According to the UNHCR, in 2008 and 2009 Canada was the second and third highest destination country for asylum-seekers, respectively, of the top 44 industrialized countries. However, Canada's ranking dropped to 16th place by 2013 as newly registered asylum-seekers have been reduced by two thirds which is, "potentially the result of recent reforms of asylum policies and the introduction of visa requirements for some nationalities featuring among the major groups of asylum seekers in Canada" (UNHCR, Asylum Trends, 2014, p. 13).

The perpetuation of precarious status through the determination process for refugee claimants in Canada contributes to many difficulties and barriers in their lives. Refugee claimants are people, with an identity, a past and a cultural heritage, who have been forced out of their countries by political turmoil, religious and ethnic conflicts, and even, social and gender prosecution. Those fleeing from endemic violence in their homelands are not only constrained in their movements to relocate and find asylum, but they are also restricted by the host nation's practices and policies which place them in a state of "legal limbo", where they are neither refugee nor citizen (Lacroix, 2004, p.1). This precariousness associated with legal status not only

excludes them from “rightful access” to social supports, it is likely to harbour stress, thereby having an impact on health (UNHCR, 2010, Article 24(b) p. 25). With limited social network upon arrival, refugee claimants are trapped in the stress of their status determination, which further exacerbates feelings of insecurity or impermanence (Kisoon, 2010; Riggs et al., 2012).

The impact of Bill C-31 on refugee claimants

In 2012, changes to Canada's refugee policy were introduced through Bill C-31, an Act to amend the Immigration and Refugee Protection Act, or Protecting Canada's Immigration System Act, as well as through regulatory changes to the Interim Federal Health Program (IFHP). These major policy reforms implemented constraints on some categories of refugee claimants, deeming them ineligible to access sources of care and support offered to other categories of claimants and Convention refugees such as GARs and PSRs. The refugee policy reforms launched in June 2012 were severe and have stimulated a great reduction in the number of new refugee claimant arrivals in Canada. In 2012 the CIC reported 20,469 in-land applications were received by the Canadian government while, only 10,380 applications were submitted in 2013 (Citizenship and Immigration, Canada, 2014). This is the lowest number of refugee claimants applying for asylum within 20 years of available data in Canada.

Under the reforms made through Bill C-31, two different categories of inland refugee claimants were established: refugee claimants from a Designated Country of Origin (DCO) and those from a non-Designated Country of Origin (non-DCO). Refugees from DCO countries are subject to shorter claim processing timelines, prohibited from appealing failed refugee claims, and if their claim for refugee status has been denied, they cannot reapply invoking Humanitarian and Compassionate grounds for up to one year (Bhuyan, Osborne, Sajedeh, & Tarshis, 2014). Bill C-31 differentiated between refugees from DCOs and non-DCOs, enabling the Canadian

government to exercise its control or sovereignty over the vulnerable population of asylum seekers in an attempt to curtail the entry of refugee claimants into the nation. According to recent reports, the largest proportion of refugees who enter Canada seeking asylum flee from Mexico and Hungary, which are countries now listed as DCOs by the Minister of Citizenship and Immigration (Citizenship and Immigration Canada, 2013). Therefore, the state excludes refugee claimants from DCO's from their right to entry, reducing their ability to claim refuge once in-land.

The Minister of Citizenship and Immigration has the authority to designate countries as safe based on the Minister's subjective opinion that the country may have independent judicial and legal rights in place for the refugee (Bhuyan, Osborne, Sajedeh, & Tarshis, 2014; Jackson, 2013). As a result, the decision that the country is safe is founded on the subjective discretion of the Minister, who may overlook the hidden crisis of violence in the nation experienced by the refugee claimants, such as domestic abuse of women, requiring them to seek protection elsewhere (WHO, 2014). According to the Executive Director of the Barbara Schilfer Clinic, "these provisions fail to recognize that women may experience systemic discrimination and unchecked gender based violence in countries otherwise considered safe... such as places like Portugal, St. Vincent and Mexico to name a few. Under Bill C-31, they would likely be forced to return to that violence" (METRAC, Barbara Schilfer Clinic & LEAF, 2012).

Furthermore, as part of developing a faster refugee determination process, individuals from DCOs face shorter timelines for processing refugee claims, particularly their Basis of Claim (BOC), limiting their period to gather documentation to 30 days, as opposed to 60 days for other refugee claimants (Jackson, 2013). As a result, these reforms increase the likelihood that DCO refugee claims will not be successful with the limited preparation time, and once denied, they are

further impaired by being prohibited to appeal to the Refugee Appeal Division (RAD).

Moreover, all individuals who apply for refugee status are required to wait at least one year after receiving a negative decision before filing a Humanitarian and Compassionate application, thus extending acts of exclusion by persisting precariousness and prolonging the determination of legal status.

Therefore, this determination process enhances the persistence of legal status precariousness for asylum-seekers from DCOs as the inevitable verdict of unsuccessful claims forces individuals to live without permanent legal status. The lack of permanent legal status or citizenship impacts their eligibility for work as refugees from DCOs cannot apply for work permits until their refugee claims are accepted or 180 days have passed since their claims were referred to the IRB (Bhuyan, Osborne, Sajedeh, & Tarshis, 2014; CDRC v. AGC, 2014). Moreover, precarious status requires refugee claimants to live with the constant threat of detention and deportation. This additional anxiety leads to the increased prevalence of mental health disorders among refugee claimants (Cleveland & Rousseau, 2006; Fazel, Wheeler & Danesh, 2005; Ryan, Kelly & Kelly, 2009). Reduced rights to work significantly affect the lives of refugee claimants in Canada.

CHAPTER 3

LITERATURE REVIEW: CANADIAN REFUGEE HEALTH POLICY

Interim Federal Health Program Reforms

1.1IFHP 2012 legislative changes

The major reform that severely impacted the lives of refugee claimants was the reformulation of the IFHP to restrict access to healthcare for asylum seekers, initially introduced by CIC on April 5, 2012 as the Order in Council (OIC): Order respecting the Interim Federal Health Program. The document proposed changes that would greatly reduce healthcare coverage for refugee claimants resulting in the loss of medical care and hospital service provisions for many claimants who had been previously covered (Government of Canada, P.W. and G.S.C, 2012).

These reforms resulted in the loss of medical care and hospital services for many claimants who had previously been covered. It also denied them access to medication drugs and supplementary coverage, which included dental and vision coverage. In-land refugee claimants from certain countries of origin would only receive medical attention if their conditions were deemed of to be of an "urgent and essential nature," posed a threat to public health or became a concern of public safety (Minister of Justice, 2013, para. 5). As a result, pregnant women have been denied prenatal and obstetrical care, those with chronic illnesses such as cancer have been refused chemotherapy and even a young child with a fever and cough was denied access to diagnostic care, such as a chest x-ray, to determine whether the child was suffering from pneumonia, a life-threatening disease (CDRC v. AGC, 2014).

The Canadian government funded the IFHP since 1957 ensuring comprehensive healthcare insurance for all refugee claimants seeking protection in Canada for over 50 years (CDRC v. AGC, 2014). Prior to the 2012 changes, identical IFHP healthcare coverage was available for GARs, PSRs, protected persons, refugee claimants, and refused refugee claimants who's negative decisions were under appeal, review or who were awaiting deportation (CDRC v. AGC, 2014). Each individual, regardless of claim approval or country of origin, was provided with complete healthcare coverage, including supplementary and drug coverage, to ensure ethical treatment of vulnerable individuals seeking humanitarian aid on Canadian soil.

Under the reforms made through the 2012 IFHP order, however, migrants were separated into categories influenced by Bill C-31 and were provided with varying levels of coverage depending on their country of origin and status. Refugee claimants, who landed from any one of 37 Designated Countries of Origin (DCO) listed by the Canadian government as countries that respect human rights and offer safe protection, would receive limited access to healthcare services upon arrival to Canada. The IFHP reforms segregated health insurance into three tiers of medical coverage: Expanded Health Care Coverage (EHCC), Health Care Coverage (HCC), and Public Health or Public Safety Health Care Coverage (PHPS), which are assigned to the different categories of refugees, unlike its pre-2012 counterpart that implemented the same level of coverage for all (CDRC v. AGC, 2014).

Expanded Health Care Coverage, which was primarily available solely to GARs, provided health care coverage equivalent to the pre-2012 IFHP coverage, in which hospital and physician services, dental and vision care as well as vaccinations and medications were covered (Sheikh et al., 2013). The second tier, Health Care Coverage, was available for PSRs and refugee claimants who did not enter Canada from a DCO (Sheikh et al., 2013). HCC delivers basic

healthcare coverage of physician, nurse and hospital services as well as laboratory and diagnostic care. However, medication and vaccines are only covered if there is a requirement to treat the disease if it poses a risk to public health or a condition of public safety concern (Seeking Solutions Symposium, 2013).

Finally, the last tier of coverage is Public Health and Public Safety (PHPS) coverage. This class of coverage was provided to failed refugee claimants and claimants from DCOs (Sheikh et al., 2013). PHPS substantially limits healthcare coverage to the provision of all care and services, medication and immunization, if and only if, it is required "to diagnose, prevent or treat a disease posing a risk to public health or, ... a condition of public safety concern" (CDRC v. AGC, 2014, para 75). Therefore, apart from the treatment for certain communicable diseases such as HIV or active pulmonary tuberculosis, no other procedures to treat, prevent or diagnose illnesses are covered.

1.2 Reaction to the 2012 reforms

Concerns for refugee claimants voiced by Canadian health organizations and professionals over a period of two years (2012 to 2014) prompted the federal government to reassess the impact of these reforms on all stakeholders involved in refugee care, including physicians, lawyers, pharmacists and refugee claimants themselves. Within one month of the introduction of the 2012 IFHP reforms, eight national health provider associations including the College of Family Physicians Canada, Royal College of Physicians and Surgeons of Canada, Canadian Association of Optometrists, Canadian Association of Social Workers, Canadian Dental Association, Canadian Medical Association, Canadian Nurses Association, and Canadian Pharmacists Association (CPhA) expressed their concerns and opposition to the changes (CPhA,

2012; Raza et al., 2012). Local Municipalities like the City of Hamilton agreed to forgo the significant rollback to the IFHP as early as May 16, 2012 and continued, “to fund refugee health care programs,” (General Issues Committee, 2012, p. 3).

On February 25, 2013, a legal challenge launched by the Canadian Doctors for Refugee Care (CDRC), joined by the Canadian Association for Refugee Lawyers (CARL) and three patients, was successfully appealed to the Federal Court of Canada, who deemed that the cuts to the IFHP carried out unjust treatment of refugee claimants (Eggertson, 2013). According to the CIC, reforms to the IFHP were introduced to "(1) Modernize, clarify and reaffirm the original intent of the IFHP as a temporary...program, (2) Alter the IFHP protocol to ensure "fairness to Canadians", (3) Protect Public Health and Public Safety in Canada, (4) Defend the integrity of Canada's refugee determination system and deter its 'abuse' and (5) Contain the financial cost of the IFHP" (CDRC v. AGC, 2014, para 53). However, these explanations have been overruled by Judge McTavish's court decision that the IFHP reforms violated section 12 of the Canadian Charter of Rights by purporting to execute "cruel and unusual treatment" of the vulnerable refugee claimant population (CDRC v. AGC, 2014).

Refugee claimants newly arriving to Canada are required by the majority of provincial health authorities to observe a waiting period of three months before they are eligible to access provincially funded health plans which usually cover physician and hospital use, however exclude drug, oral and vision coverage (McKeary & Newbold, 2010; Miedema, Hamilton, & Easley, 2008). Private health insurance is usually available to bridge the gap of coverage between arrival and access to provincial healthcare however it is a costly and unattainable alternative for most refugee claimants. Most refugee claimants in Canada have experienced the hardships of violence forcing them to migrate from typically low-income countries and arrive

with little resources (UNHCR, 2014). Therefore, refugee claimants rely on public coverage provided by the IFHP however, the 2012 reforms have complicated and limited care, negatively impacting refugee claimants, healthcare providers and other stakeholders involved in refugee care (Barnes, 2013).

Argument against objective one: Temporary Program

The primary objective of the IFHP cuts was to promote the implementation of a temporary system for all refugee claimants in an attempt to "modernize, clarify and reaffirm the [IFHP's] original intent" (CDRC v. AGC, 2014, para. 53). Instead, the temporary IFHP restricted health services to refugees. Thus, it promoted poor health outcomes for refugee claimants and intensified their already existing difficulties to access the healthcare system. Several immigration studies in Canada have found that refugees frequently face difficulties accessing healthcare due to a combination of barriers including language, transportation, cultural differences and precarious legal status (Goldring, Berinstein & Bernhard, 2009; McKeary & Newbold, 2010). Furthermore, discrimination is a barrier to accessing healthcare as refugee mothers reported perceiving discriminatory attitudes and experiences from their healthcare providers, which contributed to an additional hurdle to accessing healthcare (Wahoush, 2009). Socioeconomic factors, such as low income and poor education, tend to influence refugee claimants to avoid seeking healthcare series as well, "particularly in the face of healthcare restructuring" (Newbold, 2010, p.28).

Refugee claimants may be reluctant to seek healthcare services and may not wish to disclose their medical history for fear of a negative impact on the decision of granting them a permanent refugee status in Canada (Berman, 2009; Gagnon, 2010). Refugee claimants may also be discouraged to seek healthcare due to experiences of refusal of care or demands for fees for

treatments that should be covered. Some healthcare providers were disinclined to accept refugee patients as they are alleged to be challenging to care for due to their complex needs and uncertain IFHP coverage. According to emails obtained by the CMAJ, only nine out of thirty-three walk-in clinics in Ottawa accepted refugees as patients. Moreover, the accepting clinics would charge a visit fee of \$60.00 for refugees regardless of coverage (Eggertson, 2013).

Argument against objective two: Fairness to Canadians

The concept of developing a temporary program for refugee claimants is generated by the second objective of the reforms, asserting that the reason for the IFHP cuts is to ensure "fairness to Canadians" (CDRC v. AGC, 2014, para 53). The justification was that the former program provided more generous benefits than those received by working Canadians by their provincial and territorial programs (Olsen et al., 2014). However, these reforms do not rationally address the unfairness perceived by Canadians as "it is no fairer to Canadians to now provide vulnerable poor and disadvantaged asylum seekers with a level of health insurance coverage that is [nearly] comparable to that available to working Canadians" (CDRC v. AGC, 2014, para 947).

Refugees and refugee claimants have been found to display higher rates of tuberculosis, HIV/AIDS, diabetes and hepatitis B compared to those born in Canada (Zencovich et al., 2006; Pottie et al., 2011; Greenaway et al., 2011; Rossi et al., 2012). They are also at an increased risk of developing several vaccine-preventable communicable diseases due to under vaccination (Pottie et al., 2011). When compared to economic or family class immigrants, refugees experience more pronounced mental and physical health complications, particularly during resettlement (Fowler, 1998). Refugee claimant mothers in particular are more likely to be associated with having higher levels of psychosocial risk and unaddressed postnatal concerns than both immigrant and native-born Canadian mothers (Gagnon, Dougherty, & Wahoush et al.,

2013). Most significantly, compared to other immigrants, refugees are more likely to experience a rapid decline in self-reported health status after arrival in Canada (Pottie et al., 2011).

Therefore, the IFHP cuts suppress equitable access to healthcare for the vulnerable population of refugee claimants.

According to the 2012 IFHP cuts, refugee claimants from non-DCOs receive basic Health Care Coverage, as well as PHPS medication coverage. The coverage excludes dental care, walkers, hearing aids, home care, elective surgery or rehabilitation (Government of Canada, PW and GSC, 2012c). This means that this category of refugee claimants will receive diagnostic care provided by physicians, nurses and hospitals, and will be assessed for conditions like diabetes or cardiovascular disease. However, no refugee claimant, "even if successful in his/her application for status will receive coverage for medications [to treat the diagnosed illness] like insulin, statins or anti-hypertensive drugs" (Raza et al., 2012, p. 728).

Moreover, the provision of PHPS coverage for all refugee claimants from DCOs signifies that these claimants are not covered for physician or hospital visits, medications or supplementary care such as vision or dental care, unless it is to prevent, diagnose or treat a limited number of twenty-four conditions that were deemed a public health threat or a public safety concern. Therefore, DCO refugee claimants do not receive any form of benefit and are left without access to any healthcare services. In one instance, a man from a DCO, fleeing arrest after being injured during a political demonstration, arrived to Canada and was not covered for his surgery, prosthesis or rehabilitation by the IFH program (CCR, 2013). According to Dr. Rashid, a young child with a fever and cough was denied access to diagnostic care, such as a chest x-ray, to determine whether the child was suffering from pneumonia, a life-threatening disease, as the child was limited by PHPS coverage (CDRC v. AGC, 2014). Additionally, mental health

conditions which are also not covered for DCO claimants are exacerbated by this persistence of precarious coverage that limit claimant rights to access much needed services.

According to Raza et al., the IFHP cuts "focus on emergency treatment and aggressive infectious conditions among refugees [which] underscores a deep change in the way in which human beings are assigned value according to the social circumstances" (Raza et al., 2012, p. 728). Healthcare providers are faced with ethical dilemmas of having to refuse care to those in need due to government legislation defining refugee claimants and distinguishing claimant categories as different from being a Canadian citizen. Thus, the "fairness to Canadians" objective positions Canadian citizens against refugees by promoting the perception of refugees as threats to Canadian national identity and state sovereignty, in which members of the state or citizens play a vital role.

Argument against objective three: Protecting the Public

The third objective of the IFHP cuts to "protect Public Health and Public Safety in Canada" is undermined by the consequences and implications of reductions in the provision of healthcare. Sheikh et al. (2013) relate that the Canadian government has not clearly defined criteria, such as clinical presentations or symptoms, with which physicians could justify an investigation to rule out a disease potentially threatening to the health and safety of the public.

Argument against objective four: Defending the System

The fourth objective of the 2012 IFHP cuts aims to defend Canada's refugee determination system against refugee claimants who seek to 'abuse' the generosity of Canadians (CDRC v. AGC, 2014, para. 53). As Minister Kenny claims, the IFHP reforms will, "stop the abuse of Canada's generous and overburdened healthcare system by bogus refugees" (Government of Canada, CIC, 2012b). The term "bogus" creates the effect of "othering" for

refugee claimants by provoking the stereotypical view that they are cheats and queue-jumpers who have come to Canada to take advantage of the healthcare system (CDRC v. AGC, 2014). The justification to ‘weed out’ bogus refugees stems from the recent global mass refugee movements, which are an overtly exaggerated threat proposed by the government in fear of the depletion of economic resources (Olsen et al., 2014). The fact that resources are scarce and ‘other’, refugees, compete with us, Canadians, for them leads to the conception of refugees as a threat and elicits a sovereign response from the Canadian government to implement restrictive refugee policies.

Argument against objective five: Containing the Cost

The final objective of the federal government in favor of implementing the IFHP reforms in 2012 was to "contain the financial cost of the IFHP" (CDRC v. AGC, 2014). Before the reforms, the IFHP cost approximately \$84 million and covered 128,000 people in 2012. Following the retrenchment, the federal government expected to save \$20 million a year (Evans et al., 2014). These reforms however have increased the cost to care for refugee claimants by increasing Emergency Department use and have been absorbed by hospitals under provincial insurance, shifting and not reducing the cost of healthcare (Barnes, 2013; Evans et al., 2014).

As these reforms are likely to promote delayed health-seeking behaviour among refugee claimants, for reasons listed above, these vulnerable individuals may ineffectively manage their acute or chronic illness leading to increased probabilities of long-term disability and morbidity. According to a retrospective chart review of 1063 refugee patients from 2011 to 2014, the burden of chronic diseases such as anemia (25% among females aged 15 and over), hypertension (30%), were prevalent among the refugee population (Reddit et al., 2015a). Moreover, the study revealed there was an increased prevalence of intestinal parasites (16%) and Hepatitis B non-

immunity (61%) among this population (Reddit et al., 2015b). With poor health outcomes, refugee claimants are likely to visit the Emergency Department more frequently or for more serious concerns, exacerbating already long wait times and squeezing tight hospital and provincial health care budgets. For instance, an accepted refugee claimant, suffering from asthma did not have coverage under the IFHP to pay for a bronchodilator. Lacking insurance for medication, the claimant remained without a bronchodilator until she suffered from an asthma attack and was rushed to the Emergency Department (ED). Her costly ED visit and subsequent hospitalization could have been avoided had she been provided with proper medication, reducing the cost of care for this refugee claimant significantly (Sheikh et al., 2013). Moreover, a cost analysis at the Hospital for Sick Children reported an increase in the number of admissions to the ED, from 6.4% to 12.1% (Evans et al., 2014). This result was however statistically insignificant, due to a small study sample collected within the span of one year.

Therefore, the IFHP reforms do not reduce or contain the overall cost of care for a refugee claimant by restricting access to the healthcare system. Instead, the cuts transfer the costs to vulnerable refugee claimants themselves and potentially to hospitals that bear the costs of unpaid medical bills. According to the cost analysis at Sick Kids Hospital, after the 2012 IFHP reforms, healthcare costs for the institution significantly increased (Evans et al., 2014). Prior to the IFHP cuts, 46% of ER bills were paid by the IFHP, however, after the cuts, only 7% were paid by the IFHP. As over 90% of the ED bills were left unpaid by the government healthcare program so, this cost was assumed by the healthcare institution (Evans et al., 2014). Moreover, provinces are now absorbing certain healthcare costs no longer assumed by the federal government, creating a complex system for healthcare providers and refugee claimants to

navigate (Sanders 2012). Further research is needed to assess the cost effectiveness of refugee healthcare in the current situation after the 2014 reforms.

1.3 Introduction of the new IFHP 2014 reforms

The legal challenge, launched by the Canadian Doctors for Refugee Care (CDRC), on the basis of violating section 12 of the Charter of Rights and Freedoms, successfully justified to the federal court that the cuts to the IFHP was a form of "cruel and unusual" treatment (CDRC v. AGC, 2014, para. 1080). Furthermore, the court ruled that the 2012 IFH cuts were, "of no force or effect," in which refugees and claimants should be provided with "health insurance coverage that is equivalent to that to which . . . [they were] entitled under the provisions of the pre-2012 IFHP," (CDRC v. AGC, 2014, p. 266). Therefore, on November 4, 2014, the Federal Government of Canada announced the introduction of "Temporary measures for the Interim Federal Health Program." This new program reform was not a full reversal of the 2012 cuts, as ordered by the court; however it did restore some key health services (Government of Canada CIC, 2014a).

Periods of non-coverage continue to exist under the new regime, resulting in the formulation of provincial government-led programs aimed to facilitate refugee access to healthcare. Ontario is the sixth province to fill the gap left by the federal health reforms through the introduction of the Ontario Temporary Health Program (OTHP) after Manitoba, Saskatchewan, Quebec, Nova Scotia and Alberta (Benize, 2014). The OTHP, launched in January 2014, is a provincial health insurance plan that provides, "essential and urgent healthcare, as well as medication coverage," to refugees and claimants residing in Ontario (Government of Ontario, 2013a). More provincial programs have surfaced across the country

however, not all provide the same levels of coverage (CDRC v. AGC, 2014). As a consequence, many refugees and refugee claimants still rely on the IFHP health coverage.

The 2014 IFHP reforms have restored certain key services for select categories of refugees and refugee claimants through a more complex system of health coverage. Under this new temporary program, six types of coverage are provided (see Appendix A): Type 1: Basic, Supplementary, and Prescription Drug Coverage, Type 2: Basic and Prescription Drug Coverage, Type 3: Basic and PHPS Prescription Drug Coverage, Type 4: PHPS Basic Coverage and PHPS Prescription Drug Coverage, Type 5: Coverage for persons detained under the IPRA and Type 6: Coverage for the Immigration Medical Examination (CIC, 2014a).

Type 6 coverage for an Immigration Medical Examination is required only for those who enter the country without a permanent resident status, and are provided with either temporary or no immigration status at all. Type 5 covers the costs of delivering healthcare services and products during the period an individual is detained by the Canadian Border services Agency (CBSA). The final four types of coverage provide varying levels of Basic, Supplementary and Prescription Drug Coverage for select groups of refugees and refugee claimants.

Type 1 provides Basic, Supplementary and Prescription Drug Coverage to i) Resettled refugees who are or were receiving monthly income support through Resettlement Assistance Programs (RAPs), ii) Children eligible for the IFHP under 19 years of age, iii) victims of human trafficking, and iv) certain people who are being resettled in Canada as a result of humanitarian and compassion considerations on the Minister's initiative or public policy. For these individuals, the reforms restored access to all care, mirroring the program before the 2012 cuts, as physician, hospital, and laboratory services as well as medications and supplemental benefits, such as basic vision and dental care are covered (CIC, 2015).

Pregnant women and rejected refugee claimants from countries to which the government cannot deport, such as Iraq, Afghanistan, Congo, Haiti, Gaza, Syria, South Sudan and Somalia, are insured with Type 2 coverage, in which Basic and Prescription Drug Coverage is provided (CIC, 2015). Supplementary vision and dental care is not included for these individuals.

Furthermore, privately sponsored refugees, active refugee claimants currently awaiting a claim decision and protected persons are covered by type 3 Coverage: Basic and PHPS Prescription Drug Coverage (CIC, 2015). While ineligible refugee claimants, suspended refugee claimants, and rejected refugee claimants who can be deported are subject to Type 4: PHPS basic coverage and PHPS Prescription Drug Coverage (CIC, 2015).

Therefore active, ineligible, suspended and rejected refugee claimants, privately sponsored refugees and protected persons, who are not children, pregnant women or from a country to which deportation is banned do not have access to medications as they did before the cuts. These groups continue to be covered for medication only if their condition poses a threat or concern of public health or safety (Goel, 2014). Moreover, refugee claimants who are suspended, rejected and ineligible but allowed to apply for Pre-Removal Risk Assessment (PRRA) are provided with no care at all, except in the case to prevent or treat a condition that is a concern to public health or public safety (Goel, 2014). Whereas, before the 2012 cuts, these individuals were provided with insurance until the date of deportation to ensure that their claim was truly invalid under Canadian refugee determination policies (Goel, 2014).

1.4 Rationale

The new "Temporary measures for the Interim Federal Health Program" instituted by the government has six varying levels of health insurance in which certain groups of refugee

claimants are still provided with no care at all unless their condition is a concern of PHPS. The creation of three types of coverage in 2012 created financial issues for hospitals and confusion among providers regarding the provision of healthcare for refugees and claimants (Barnes, 2013; Evans et al., 2014). Therefore, it can be assumed that funding regulations have consequentially become more complex and the confusion has augmented with the introduction of six tiers of health coverage.

Moreover, due to poor or non-existent knowledge translation or policy implementation efforts, it can be assumed that certain healthcare professionals or workers may not even be aware of the 2014 changes, and may be still implementing the 2012 cuts. According to Howlett, Ramesh and Perl (2009), implementation was regarded as problem free until the 1970's when studies confirmed certain programs were not achieving their intended objectives because of poor policy implementation. Implementation theory emphasizes the use of both complementary approaches (top-down and bottom-up), in which the examination of decisions at the government level and those at the public- or recipient-level of policy decisions are undertaken. The success or failure of many programs is dependent on policy subsystems, consisting of key stakeholders, and their involvement with the decision-making and implementation process. The aforementioned assumptions are only hypotheses regarding what the current situation of refugee claimant access to services and health professional provision of care may be in reality. Therefore, more information is needed to map out the impact of the 2014 IFHP reforms on this policy subsystem consisting of diverse stakeholders.

1.5 Key Stakeholders

Four major categories of refugee health policy stakeholders include: policy makers and government officials, civil society organizations, professionals and practitioners as well as refugees and refugee claimants themselves.

Policy Makers and Government Officials

For most Canadians, the publically funded universal healthcare model, known as Medicare, is one of the foremost policy features of the nation that embodies Canadian values (Mendelsohn, 2002). These values include ones that support a publically funded model where it is believed that all Canadians should have access to health care services based on medical need, rather than the ability to pay (Commission on the Future of Healthcare in Canada, 2002). These Canadian values were extended to migrants, or future Canadians, especially those fleeing from religious, political or ethnic persecution through the creation of the Interim Federal health Program (IFHP) for refugees and refugee claimants. The IFHP was established by the Federal Government in 1957, "introduced for humanitarian reasons" to "provide eligible clients with access to essential and emergency medical/ pharmacy/ optical/ dental services that will contribute to optimal health outcomes in a fair, equitable and cost-effective manner" (Government of Canada, 2006, p. 5).

In 2012, policy makers at the federal government level retrenched access to essential and emergency healthcare services for some refugees and refugee claimants. In the press release announcing the reform, Citizenship, Immigration and Multiculturalism Minister Jason Kenney announced, "Our government's objective is to bring about transformational changes to our immigration system so that it meets Canada's economic needs. Canadians are very generous people and Canada has a generous immigration system. However, we do not want to ask Canadians to pay for the benefits for protected persons and refugee claimants that are more

generous that what they are entitled to themselves" (Government of Canada, Citizenship and Immigration Canada (CIC), News Release, 2012b, para. 2). Members of the federal government can be recognized as primary policy decision-makers who proposed the initial limitation of access and provision of healthcare for refugees and refugee claimants in Canada.

Historically, the federal government has borne the constitutional responsibility for the provision of healthcare for certain groups that fall under its jurisdiction: military, First Nations and Inuit communities, federally imprisoned inmates and refugees. In 2014, however, once interest groups raised concerns that the 2012 retrenchment of health services were generating negative effects on refugee health outcomes and within navigating the healthcare system, the provincial governments (Ontario, Quebec, Manitoba, Saskatchewan, Alberta, Nova Scotia and recently, New Brunswick) responded with the creation of new health coverage plans or bridging healthcare plans for this vulnerable population. The 2012 cuts were found to be a form of cruel and unusual treatment, violating section 12 of the Charter of Rights and Freedoms, in which the federal government was obligated to restore services through the 'Temporary measures IFHP'. It was, however, the provincial governments who decided to act for the first time as policy-makers in the field of refugee health. Thus, members of the provincial government such as Ontario are key policy makers for this research.

A policy maker includes civil servants ranging from senior to junior level and to those in connected agencies and regional government; it includes politicians in government and opposition, the people who might not directly make the decisions, but as advisers can strongly influence them. Thus, key stakeholders for this study included policy makers at the organizational level with the ability to strongly influence refugee health policy with their connections with the Government of Canada.

Role of Civil Society Organizations

Civil society organizations (CSOs) are non-state, not-for-profit, voluntary organizations that are formed by the people in the social sphere. According to Veneklasen (1994, p. 6):

Civil society is a sphere of social interactions between the household (family) and the state which is manifested in the norms of community cooperative structures of voluntary associations and networks of public communications . . . norms of value of trust, reciprocity, tolerance and inclusion, which are critical to cooperation and community problem solving.

They are also especially important in the area of providing refugees and refugee claimants with health and social services. Many CSOs that provide services to this vulnerable population are community-based organizations that complement the activities of professionals by providing services of a broad spectrum. More importantly, these community-based organizations (CBOs) play a major role in the implementation of the new 2014 IFHP, which was formulated by the government. Therefore, to achieve sustainable development of this program, the involvement of CBOs and their perspective is necessary since they work for development and can make important inputs to the policy making process.

Community –based organizations provide legal services, primary healthcare, settlement services and integration services to promote the well-being of individuals fleeing from endemic violence, persecution and torture. CBOs help mitigate the impacts of the post-migrations stressors derived from the constricting immigration policies of our time. In policy development, CBOs provide information that is vital to service the refugee and refugee claimant community. CBOs can monitor the application of laws and discover where laws or policies are compatible with community interests, design programs that complement rather than undermine or contradict

government policies. Therefore, it is essential to obtain the views and perspectives of CSOs involved in the refugee and refugee claimant care scene, regarding the impacts of the 2014 IFHP reforms.

Professional and Practitioners

A number of different organized professional interest groups have been identified in the literature surrounding the refugee healthcare arena, including physicians, social workers and lawyers. Physicians primarily have professional responsibilities to provide medically necessary care to refugees and refugee claimants regardless of their country of origin, resident status or their ability to pay (Caulford & D'Andrade, 2012). According to Raza et al. (2012, p. 729), physicians have a moral obligation to serve all individuals regardless of status as a refugee or not: "We are front-line physicians. We are the ones who hear the horrific stories of persecution, torture and sometime, rape. The responsibility to advocate for public policy that promotes our patient's health is ours."

With the 2012 IFHP alterations, the Canadian Doctors for Refugee Care were formed and advocated for the reversals of the cuts as they reduced healthcare for refugees and refugee claimants. The cuts limited the provision of essential care for refugees and refugee claimants, for example, by eliminating funding for physicians to perform diagnostic tests. Thus, physicians lost funding to evaluate patients for conditions such as psychoses, a mental illness characteristic of many refugees and refugee claimants enduring torture or violence from their country of origin. Additionally, physicians were left to ponder as to whether or not the medications they prescribed would be covered; "What are we going to tell that insulin-dependent patient with diabetes from the 'wrong' country whose insulin is no longer covered? What about the pregnant woman who is not covered for routine prenatal care? Inexcusable," (Raza et al., 2012, p. 729). Thus as key

stakeholders who directly provide healthcare for this vulnerable population, it is essential to obtain the view of physicians regarding the impact of the 2014 IFHP reforms.

Secondly, social workers have a professional duty to assist refugee claimants and refugees through their integration process upon arrival in Canada, including initial assessments of their mental and physical well-being. Social work is a professional discipline that seeks to improve the quality of life for the individual or family, which includes providing information on how to access healthcare services. As the initial point of contact for the refugee or refugee claimant, it is the responsibility of the social worker to involve a number of different sectors to build a coordinated response to the complex psychological and physical needs of the refugee or refugee claimants (NSW Refugee Health Service, 2000). After the 2012 cuts, the Ontario Association of Social Workers (OASW) sided with the doctors as an interest group advocating for a reversal of the cuts to promote access to healthcare for this vulnerable populations (OASW, 2012). Therefore, as the 2014 reforms have taken place, the perspective of social workers on the new reforms is absent from the literature and would be essential in evaluating the current effectiveness and implementation of the new IFH program.

Finally, lawyers are crucial stakeholders in the refugee health domain. It was the collaboration of the lawyers' and doctors' group that launched the legal challenge against the 2012 IFHP reforms arguing the retrenchment of services which violated several clauses of the Charter of Rights and Freedoms. According to the challenge, the retrenchment threatened rights to life and security of refugees and refugee claimants contrary to section 7 of the Charter. It encompassed cruel and unusual treatment in violation of section 12 of the Charter and contrary to section 15, it discriminated against certain refugees and refugee claimants from Designated

Countries of Origin (DCOs). According to Lorne Waldman, immigration lawyer and member of the Canadian Association for Refugee Lawyers (CARL),

The impact of the policy is seen both by doctors who are primary caregivers and have to deal on a daily basis with refugees who don't get health coverage . . . and we as lawyers who see the refugees when they come into our offices. (Eggertson, 2012, p. E276).

Therefore, lawyers involved with refugees and refugee claimants are an essential professional interest group for obtaining information and perspectives regarding the impacts on the current situation of access to healthcare after the 2014 IFHP reforms.

The Role of Refugees and Refugee Claimants

The reduced coverage implemented in 2012 by the federal amendments to the IFHP has dramatically impacted the health and well-being of refugees and refugee claimants. The rate of child refugee emergency admissions nearly doubled six months after the cuts (Evans et al., 2014), refugee claimants are frequently accessing emergency services due to the lack of access to preventive care (Sheikh et al., 2013), such as medications like insulin, statins, and anti-hypertensive medications (CDRC v. AGC, 2014). Moreover, refugees arrive with underlying medical conditions such as poor dental health due to a lack of nutrition and poor mental health derived from pre-migration stress associated with trauma, turmoil and violence from their country of origin (NSW Refugee Health, 2000).

In addition to pre-migration stress, refugees and refugee claimants confront a host of post-migration stressors upon arrival to the host country. First, they must obtain housing, gain employment, develop new networks of social support, seek healthcare, overcome prejudices and discrimination and learn the language, culture and customs of a new society. These post-migration stress factors influence mental and physical health of this group of people and in the

case of Canada, uncertainty involving their legal immigration status attributed to by restrictive policies and practices such as the IFHP promote post-migration stressors as well (Kirmayer et al., 2011). According to Gagnon et al. (2013), Refugee claimant mothers in particular are more likely to be associated with having higher levels of psychosocial risk and unaddressed postnatal concerns than both immigrant and native-born Canadian mothers. Therefore, with the restorations of certain services for this population as of 2014, it is essential to obtain refugee and refugee claimant perspectives on their current healthcare coverage under the IFHP 2014 reforms.

CHAPTER 4

STUDY METHODOLOGY

Study Design

1.1 Design and Stakeholder Perspectives

As policy-making is an information-intensive process, stakeholders who possess information on the current situation possess value (Howlett, Ramesh & Perl, 2009). Policy effectiveness can be judged using several methods, such as assessing its' ability to achieve its primary objective, the cost and efficiency of implementation, trade-offs between benefits and disadvantages, or finally, the acceptance of the policy and its policy-making processes by key stakeholders. Acceptance of key stakeholders refers to how the policy is judged by relevant actors and therefore involves subjective elements such as stakeholder perspectives (Swinburn et al., 2005). The intent of this study is to obtain the perceptions of key refugee health policy stakeholders to assess the impact of the 2014 changes to the Interim Federal Health Program (IFHP). The objective of the IFHP is to promote the health and well-being of asylum seekers and refugees arriving in Canada for safety. The intermediate effects of the policy reforms are the following: With the restoration of certain services for refugees and refugee claimants, this reinstatement will lead to higher rates of access to care and provision of care by professionals and practitioners to recover refugee health and well-being. This flow of effects is illustrated in the logic model (Figure 2) which represents the theory of the 2014 IFH reforms and the expected effects. The intermediary effects or goals of the policy are improved access and provision of healthcare for the refugee and claimant population.

This study aims to examine the perception of key stakeholders regarding the impact of the 2014 reforms on the policy's intermediary goals: access and provision of healthcare. Analysis

of intermediate effects strengthens the assumption of causality because they are in close proximity to one another on the logic model and less 'distant' than the overarching outcome. Their cause-effect relationship with the policy is easier to establish and if policy effectiveness can be displayed up to a certain point in the chain of effects, then its actual contribution to the primary objective, which is the improvement of health for refugees and refugee claimants can be evaluated. Furthermore, analysing immediate effects renders it possible to distinguish steps that do not function well resulting in early identification of problems that need to be resolved.

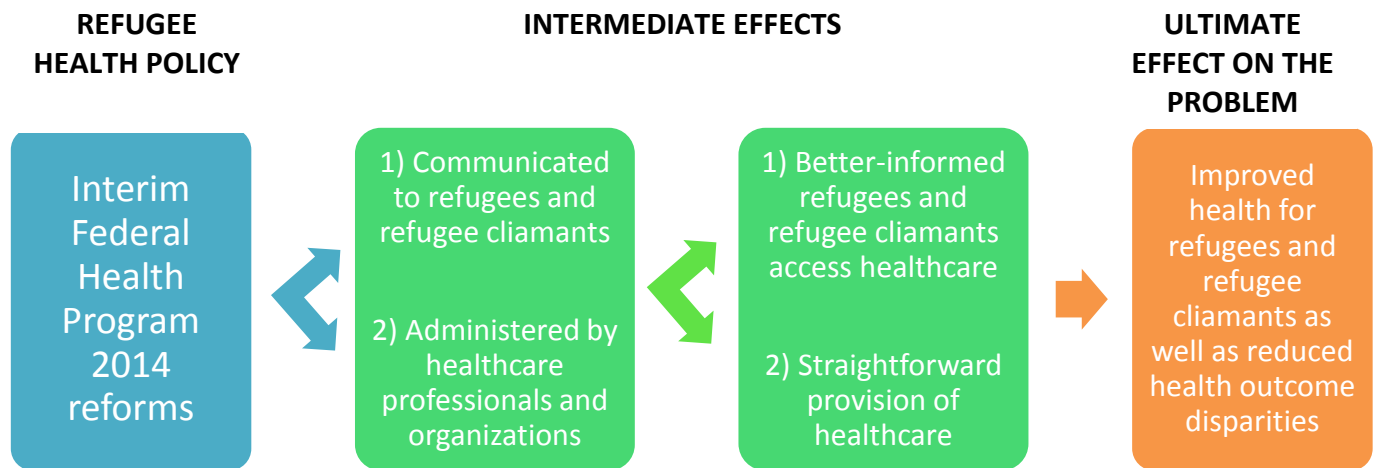


Figure 2. Logic Model of the 2014 Temporary Measures of the IFHP

1.2 Objectives and Research Questions

This study aims to examine the perspectives of key stakeholders on their position, interest and influence regarding the 2014 IFHP and the extent to which the policy's intermediate goals are achieved. The research aims to answer the following question: 1) What are the perceptions of key stakeholders regarding the impact of the 2014 IFHP reforms? This question is divided into two parts: a) What are the positions, interests and influences of key stakeholders on the 2014

IFHP reforms? b) What are the conditions surrounding IFH policy adoption and implementation that impact access and provision in Canada as perceived by key stakeholders?

The primary objective is to obtain the perceptions of diverse refugee health stakeholders impacted by the IFHP reforms, focusing on the 2014 changes by conducting key informant interviews with stakeholders regarding refugee and refugee claimant access to the healthcare system and healthcare professional provision of care within the healthcare system. The secondary objective is to examine how effectively the 2014 changes are being adopted and implemented based on stakeholder awareness and more importantly, whether they will benefit/align with the interests of stakeholders such as refugee claimants, healthcare providers and government officials who have a vested interest in and are impacted by the IFHP changes.

Study Procedures

2.1 Approval, Consent and Confidentiality

This research was approved by the Hamilton Integrated Research Ethics Board on May 15, 2015 (Appendix B). Consent forms and study information were provided for all stakeholders prior to conducting the interview (Appendix C). This study was explained to interested participants by a settlement agency staff member, who acted as a translator during in-depth interviews with refugees and refugee claimants unable to fluently speak English. Other stakeholder groups were informed of the study content by the researcher prior to conducting the interviews.

Among key stakeholder groups, apart from the vulnerable group of refugees and refugee claimants, consent was first obtained via email if participants agreed to take part in the study. Written consent was obtained in-person prior to the interview by the primary researcher conducting the interview. In case of a telephone interview, oral consent was obtained by the

researcher prior to the interview. Participants were be given as much time and information as needed to provide informed consent for the study. The participants were informed of any risks, such as psychological risks from triggering traumatic experiences involved with pre-migration stress, or risk associated with employment (as government officials, policy makers, and representatives of civil society organizations may fear that their responses could affect their career). Participants were informed that they could withdraw at any point in the study by notifying the researcher.

To ensure participant privacy and confidentiality, the interview script consisting of the electronic transcript and audio file was coded with a personal identification number (PIN). The PIN was used to ensure personal information was de-identified in order to maintain participant confidentiality. A digital Sony recorder was used to record participant interviews, which was securely transferred to a secure password protected laptop using the recorder's specific USB cable. Both recorder and USB cable will be kept in a double locked room in order to ensure security of the data collected. The password-protected laptop was used to then subsequently transcribe interviews verbatim by the researcher to further protect participant data. Paper copies of the interviews were kept in a locked filing cabinet separate from the consent forms and all data collected from this study was stored electronically on a password-protected laptop. Only the research team had access to the information. Finally, all data will be deleted from the laptop three years after completion to safeguard the information for use in future paper or journal articles and if participants and researchers require clarification of the data collected in the future.

2.2 Identification of Stakeholder Categories

The increasing prominence of stakeholder analyses reflects a growing recognition of the influence of a variety of stakeholders on the policy decision-making process (Burgha &

Varvasovszky, 2000). Stakeholder identification and analysis is the first step in the stakeholder identification process (Freeman, 2001) as it aids in distinguishing stakeholders from those who are not, and focuses on those who need to be engaged. Poorly structured or unsystematic stakeholder identification contributes to missing valuable perspectives or limiting participation to groups readily known to healthcare researchers. Often, marginalized groups, such as refugees and refugee claimants, are lacking from the academic literature (Reed et al., 2009). Therefore, the stakeholder identification framework, developed by Schiller et al. (2013) provides a systematic approach to ensure comprehensive representation of diverse perspectives on the IFHP 2014 policy reforms.

Schiller et al. (2013) identified seven categories of stakeholders to address the intersection of older adult mobility with the built and social environments: Policy makers and government officials, research community, practitioners and professionals, private businesses, civil Society organizations, health and social service providers and the public. The authors created the aforementioned categories based on public health policy. However, this research focuses on migrant health, specifically refugee and refugee claimant health policy. Therefore, certain categories were removed and/or modified to tailor the framework to the current research. Firstly, private business stakeholder category was removed as many refugees and refugee claimants are not economically stable to afford private insurance or seek healthcare apart from what is provided under the IFHP (Caulford & D'Andrade, 2012). Second, as this research focuses not on public health policy but on refugee health policy, the targeted stakeholder group affected by the policy under consideration was modified from the public stakeholder category to the more nuanced refugee and refugee claimant stakeholder category.

Third, health and social service providers were combined with civil society organizations as most health and social services providers to the refugee and refugee claimant population in Canada are community-based organizations. The WHO (2015) classifies these organizations as part of civil society; they "occupy the 'social space' between the family and the state, excluding political parties and firms" (para. 1). Finally, the research community stakeholder group was removed because many of the informed stakeholder categories consisted of members who were involved with research activities apart from their main role and involvement with the refugee and refugee claimant community. Therefore, this study identified four key stakeholder categories affected or affecting the 2014 recent reforms to the Interim Federal Health Program: 1. Policy makers and Government officials, 2. Professionals and Practitioners, 3. Civil Society Organizations, and 4. Refugees and Refugee Claimants.

2.3 Recruitment and Sampling

Purposive sampling methodology was used to recruit stakeholders. Purposive sampling is a non-probability sampling that selects respondents based on particular knowledge already held and attempts to ensure that "certain types of individuals or persons displaying certain attributes are included in the study" (Berg, 1989, p. 110). Thus, stakeholders recruited were either affected by or influenced refugee health policy, maintaining a high level of interest in the issue. An informative email or phone call was the primary mode of contacting potential stakeholders (Appendix F). Stakeholders were also recruited in-person at the North American Refugee Health Conference, a convergence of key stakeholders highly interested in the 2014 IFHP reforms. Moreover, for vulnerable stakeholders a part of the refugee or refugee claimant category, an individual within that stakeholder's circle of contacts was initially contacted to reduce risks and

fear of participation. Snowball sampling was also minimally used to obtain further data sources and contacts through participant recommendation (Streubert-Speziale & Carpenter, 2007).

2.4 Limitations

Semi-structured in-depth interviews are subject to individual bias and recording error through poor or inaccurate articulation (Barriball & While, 1994). More importantly, anonymity among refugees and claimants was an issue during data collection. When approached through someone within their circle of contacts, the majority of refugee claimants were willing to share their perspective, but they declined to sign the consent form or be recorded for fear their identity would be revealed. These individuals fear that participation may negatively affect their refugee determination process and are very careful as to the information they give. Since refugees and claimants are in this vulnerable position, anonymity is an important concern and therefore, once this concern was expressed these individuals were not interviewed. A final limitation was encountered when recruiting policy makers and government officials for this study. As legal challenges against the 2014 reforms are currently underway, political conditions prevented access to certain members of government for collection of data, limiting access to some government leaders.

Data Collection

3.1 Qualitative Approach and Interviews

Semi-structured, key informant interviewing constituted the main method for generating data in this study. The reasons for choosing this method are linked to the purpose of this study, which is to gather stakeholder perspectives on the current IFH program. As this research aims to analyse the impact of policy, phenomenology aids in the preclusion of "premature[ly] focusing on a limited number of aspects of the issue, to the neglect of others which may emerge during the

process of data collection and analysis" (Varvasovzsky & Burgha, 2000). A researcher applying phenomenology is concerned with the lived experiences of the people involved with the issue that is being researched (Greene, 1997), justifying the use of this qualitative approach in the present stakeholder analysis.

The qualitative interview process lasted over six weeks and all interviews were digitally recorded and transcribed verbatim by the primary researcher. All interview guides were designed according to stakeholder analysis guidelines (Schmeer, 1999). The interview guides were further developed and refined through consultation with thesis committee members and supervisor, experts in refugee health and/or qualitative research (Appendix D). The interview guides were semi-structured, keeping the focus sufficiently broad to allow for hidden or emerging themes (Varvasovzsky & Burgha, 2000). The interview style and probes were developed during the interview to maintain a "conversation with a purpose" style, using an open-ended approach to gather data (Mason, 1996). Semi-structured in-depth interviews enable exploration of attitudes, values beliefs and motives while facilitating comparability when all questions are answered by each respondent, as in the case of this study (Smith 1975; Bailey, 1987). Throughout data collection, semi-structured in-depth interviews lasted 15 minutes to 90 minutes.

Furthermore, a separate guideline was developed for the refugee and refugee claimant stakeholder group, in which certain questions were altered or removed in light of interviewing vulnerable individuals (Appendix E). This guideline still followed the same basic line of enquiry as the general interview guide (Patton, 2002). The general interview guide included 21 questions: 3 questions to collect information defining stakeholder involvement; 2 questions related to familiarity with the IFHP and its recent reforms; 6 questions to collect stakeholder perspective of

the reforms; 8 questions about the impact of the IFHP reforms on accessing and providing care for refugee claimants in Canada; and 2 questions to close the interview with final comments and recommendations.

Key informant interviews were conducted either in-person or by telephone, depending of the respondents' preference. If in-person, the interview locations were also based on interviewee preference. Many interviews were conducted in stakeholder offices and some at neutral locations, in private organizational rooms or at the participants' home (for refugee and refugee claimant interviews). Theoretical saturation was reached at 12 interviews. At this point, themes regarding barriers or facilitators, what works and what does not work, were being repeated by respondents. Following the 12th interview, 11 more were conducted to verify previously verified data and collect additional stakeholder positions on the IFHP reforms to achieve a spectrum of opinions in which opposing and supporting sides were represented.

3.2 Sample Size and Study Population

According to the literature, qualitative study sample size is determined by how many interviews it takes to reach theoretical saturation, a state in which no further themes are found (Galser, 1965). Using non-probabilistic sampling techniques Guest et al. (2006), convey that saturation occurred within 12 interviews with the broader themes apparent after 6 interviews. Therefore approximately 6 stakeholders were recruited per stakeholder category to ensure major themes from each of the four stakeholder categories would be identified.

Moreover, Fugard and Potts (2015) introduced a tool to help estimate sample size for the particular context of a study when investigating patterns across participants through thematic analysis. As thematic analysis is frequently used to analyse qualitative data in healthcare and other sectors, theme prevalence, desired instances of a theme and power of the study is used to

determine approximate sample size. Using Fugard and Potts (2015) parameters, to have 80% power to detect two instances of a theme with 15% prevalence (calculated using the lowest prevalence of interested theme by likelihood of theme emergence [$0.3 \times 0.5 = 0.15$], results in an approximate number of 21 participants needed to carry out the study. As the total number of stakeholder is 23 ($n=23$), the sample size is appropriate for this research.

The eligibility criteria included adults 18 years or older who are defined as key stakeholders in refugee health policy. Stakeholders are defined as actors who have an interest in the issue under consideration, who are affected by the issue, or who have or could have an active or passive influence on the decision-making and implementation process (Schmeer, 1999). For the purposes of this study, potential stakeholders include all those whose interests, actions and motivations are associated with the refugee claimant population and wish to share their perceptions regarding access and provision of care under the IFHP reforms.

Data Analysis

4.1 Literature Review and Inductive Content Analysis

The review of literature was conducted using a set of a priori questions to guide deductive analysis of relevant documents pertaining to the IFHP reforms. The documents included health equity reports from policy institutions, policy summaries from government websites, research articles on refugee health in Canada, as well as articles on refugee determination system particularly focusing on the recent changes to immigration policy such as the introduction of Bill-C-31. Moreover, research articles evaluating the 2012 reforms to the IFHP, advocacy group reports of the impacts of the 2012 reforms and media articles on the current situation provided relevant content to understand the evolution of refugee policy leading to the adoption of the 2014

IFHP reforms. This literature review is integrated into the introduction section in Chapter 2 and Chapter 3 to provide policy context and to frame the issue.

Following the literature review, an inductive approach was used to develop research questions and perform content analysis of the data. As this study's aim was to provide knowledge, new insights and practical guide to engaging stakeholders, inductive analysis is recommended, especially when little is known about the research phenomenon or the knowledge is scattered (Elo & Kyngas, 2008). For successful content analysis, data should be reduced to concepts that describe the research phenomenon (Cavanagh, 1997; Elo & Kyngas, 2008; Hsieh & Shannon, 2005) by creating categories, concepts or conceptual map (Elo & Kyngas, 2008; Morgan, 1993).

4.2 Open-coding and Coding with N-Vivo 10

All 23 digital recordings were transcribed solely by the primary researcher to ensure a very close and thorough understanding of the data, and to assist in the thematic analysis of the interview transcripts. Initial coding and analysis of data followed the transcription of each interview. Transcripts were read, re-read, and after reading through the data multiple times, notes were taken to identify significant and recurring themes (Liamputtong, 2009). Codes were used to label concepts and meanings onto coding sheets (Elo & Kyngas, 2008). As this process developed, data were broken down into increasingly specific categories and sub-categories that reflected information relevant to participants' perspectives and understandings of the 2014 reforms to the Interim Federal Health program. As transcripts were read over and highlighted based on different codes, themes both within and across the groups of stakeholders were more easily distinguishable after each series of coding. Coding consisted of data reduction and manipulations to generate different levels of interpretation (Coffey & Atkinson, 1996).

The coding process incorporated both a priori codes based on the literature as well as inductive codes derived from phrases used or concepts mentioned by participants using a constant comparative analysis approach with QSR International's NVivo 10 qualitative data analysis software. A priori codes refer to the set of existing codes that are developed before examination of data. They are usually informed by initial research goals and inform the interview topics. Inductive codes refer to those emerging themes and topics raised by respondents themselves. NVivo 10 was used to organize the large amount of data collected from interviews and facilitate identification of codes. Kaefer, Roper and Sinha (2015) suggest that data analysis software programs like NVivo make the analytical process more flexible, transparent and ultimately more trustworthy.

4.3 Abstraction of Themes

In qualitative content analysis, the abstraction process is the stage during which concepts are created (Elo et al., 2014). Preliminary coding schemes (nodes) were sent to thesis supervisor for review. The research data was subsequently coded using research questions as a guide to generate preliminary findings under nodes or themes using NVivo 10. General descriptions of research are formulated into broad conceptual categories through theme abstraction (Elo & Kyngas, 2008). Broad categories included Benefits of the 2014 IFHP reforms and facilitators of access in the current situation, which involved further analysis and simplification of the data to reflect participant responses. Other broad categories such as disadvantages or the current program led to barriers identified by respondents that were analysed in a similar process using NVivo. However, for these topics, themes were developed from the data and existing literature. Therefore, the Health Care Access Barrier (HCAB) model developed by Carrillo et al was used and modified to include social determinants of health. Four barrier categories were included:

cognitive, structural, financial and socio-political (see Figure 3). Sub-themes or barrier dimensions were abstracted to answer all research questions. Similarities and differences in perceptions of themes were analysed.

4.4 Stakeholder Analysis

Stakeholder analysis is the process of systematically gathering and analyzing qualitative information to determine whose interests should be taken into account when developing and /or implementing a policy or program (Schmeer, 1999). As the current IFHP is temporary, this research conducted a stakeholder analysis to guide decision-makers prior to the implementation of a permanent IFHP, through a consensus-building process in which the majority of stakeholder interests can be taken into consideration. As a stakeholder analysis generates information on "relevant actors" to understand their behaviours, agendas, interests and influence on the policy decision-making process (Brugha & Varvasovsky, 2000, p. 239), this research provides information that can be used to work more effectively with stakeholders, facilitate transparent implementation decisions or objectives, understand the policy content and assess the feasibility of future policy options.

As part of the stakeholder analysis, matrices were developed to describe data. Matrices are a cross tab format with a set of variables forming a row and another set forming a column. The matrices arranged data under each stakeholder category to display patterns and relationships between interests, positions and influence of key stakeholders. For the next level of analysis, a stakeholder map was synthesized to analyse the relationship between stakeholder position on the IFHP 2014 reforms and their ability to influence policy (Nutt & Backoff, 2007). This map provided information on the type of key stakeholders in the current policy arena which subsequently highlight particular strategies for stakeholder engagement.

4.5 Quality or Trustworthiness

One issue frequently debated in qualitative research is the quality or trustworthiness of the conclusions (Miles & Huberman, 1994). There are four criteria developed to ensure trustworthiness in qualitative studies: Credibility, Transferability, Dependability and Confirmability (Lincoln & Guba, 1985). These criteria have been demonstrated through strategies by which rigour can be checked: triangulation, thick description and audit trail (Ballinger, 2006).

Triangulation refers to gathering data using different methods or data sources. In this study, data was collected using interviews with four different stakeholder groups: refugees, policy makers, professionals and organizations, as well as attending conferences on refugee health and conducting a comprehensive literature review. Thick description refers to providing extensive details about context and participants included. Using supplementary sources of data (literature review) with interviewee data, thick description was generated. Thick description was displayed through content and constant comparative analysis approaches using the coding process, creation of categories, identification of issues and generation of themes. Finally, to support audit trail, "in which the researcher demonstrates how her work and thinking progressed," the research process from literature review to research questions, conceptual model and research methods were very clearly represented (Ballinger, 2006, p. 239). Data collection and data analysis using NVivo 10 allowed for audit trail through registering each action undertaken through the data analysis software in the log file, making the methodological and analytical process more comprehensible and retraceable.

4.6 Limitations

This stakeholder analysis provides “snapshots” of the current situation regarding the IFHP 2014 reforms where positions, interests and influence are subject to change (Varvasovszky and Burgha, 2000, p.344). Observations are made cross-sectionally over a limited time period to map the current stakeholder interests, positions and influences, which are liable to change in the future as the political context of the policy formulation is unstable and subject to sudden and unexpected transformation, as were the 2012 and 2014 changes. Therefore, the relevance of this analysis for informing policymakers regarding the management stakeholder engagement decreases as time moves forward. The limitation of the stakeholder analysis is that information is cross-sectional or valid for a point in time.

CHAPTER 5

FINDINGS PART ONE: STAKEHOLDER ANALYSIS

Introduction

This chapter presents the perceptions of key stakeholder categories regarding the impacts of the Interim Federal Health Program reforms introduced in 2014 on access and provision of healthcare for refugees and refugee claimants in Canada. A brief demographic profile of the key stakeholders is provided. The presentation of findings is organized in relation to the first research question: 1) what are the positions, interests and influences of key stakeholders regarding the impacts of access and provision of healthcare under the new Temporary Measures IFHP?

Once policies, such as the IFHP, are implemented, their effectiveness at achieving its objective is judged from multiple stakeholder perspectives. In the field of health policy, evidence-informed approaches to decision making has been favoured. Many governments have planned to analyse policies and programs to determine their effectiveness or in simpler terms, 'what works' (Nutley, Walter & Davies, 2007). Effectiveness of the 2014 IFHP reforms will be assessed in the next chapter by assessing the extent to which the stated policy goals were achieved according to each stakeholder. In this chapter, implementation will be evaluated by examining the acceptance factor of different stakeholder categories regarding the IFHP 2014 policy and the policy making process by conducting a stakeholder analysis (Morestin, 2012).

A stakeholder analysis has been conducted to generate knowledge about actors in the relevant area of research for understanding their interests, positions, influence and resources they bring for the implementation process of the IFHP reforms. Relevant stakeholders include policy makers and government officials, professionals and practitioners, civil society organizations and refugees and refugee claimants. Policy development has tended to include both powerful and

powerless stakeholders in the analytical process (Bryson, 2004). As noted by Burgha and Varvasovszky (2000), interested stakeholder groups such as government officials can influence policy decisions and affect policy content. While relatively powerless groups such as refugees and refugee claimants receiving reduced healthcare coverage are greatly impacted by the policy. Good policy development demands the consideration of all stakeholders (Freeman, 1999) whether powerful, knowledgeable, resourceful or deeply affected by the problem, such as refugee health, during all stages of the policy cycle.

Demographic Profile of Key Stakeholders

Out of 23 key stakeholders, 5 belonged to the policy maker and government official stakeholder category, 6 key stakeholders represented civil society organizations, 6 key stakeholders were part of the professional and practitioner group and finally 6 key stakeholders were refugees and refugee claimants.

Table 1. Work Experience and Lived Experience of Key Stakeholders in Years

Work Experience of Key Stakeholders and Lived experience of Refugee and Refugee Claimant Key Stakeholders										
Years	Policy makers & Government Officials		Professionals & Practitioners		Civil Society Organizations		Refugees & Refugee Claimants		Total	
	n	%	n	%	n	%	n	%	n	%
0-5	2	8.7	1	4.4	2	8.8	4	17.4	9	39.3
5-10	1	4.3	3	13.0	1	4.3	2	8.7	7	30.4
>10	2	8.7	2	8.7	3	13.0	0	0.0	7	30.4
Total	5	21.7	6	26.1	6	26.1	6	26.1	23	100.0

Work experience and involvement in the refugee health policy domain ranged from 1 to 25 years for policy makers and government officials, 4 to 27 years for professionals and practitioners, and 1 to 27 years for civil society organizations (see Table 1). Lived experience for refugees and refugee claimants during the 2012 and 2014 IFHP reforms ranged from 2.5 to 6 years.

Policy makers and Government officials

3.1 Involvement of Policy makers and Government Officials

In this research, five stakeholders in the policy maker and government official (PG) category were identified. These stakeholders had present or previous experience in policy-making either at a government or non-governmental capacity:

I am the policy director so the [Organization Y] . . . does work on social determinants of health and health equity so we don't have a particular focus on refugees per se but refugee claimants are a vulnerable group and need health and health equity so our involvement has always been within the context of the health equity work we don't have any kind of service provision we do research and policy work and so that means that we've done pieces of work that are relevant to refugee claimant communities. (PG 3)

I don't have a direct involvement with the refugee claimant community; work at the policy advocacy and public awareness level, that's my role. (PG 4).

One of the three was a former government official federally and provincially:

I don't have any direct role with refugees, but I am a researcher analyst, advocate, consultant, and I teach immigration refugee policy so I am very current about the policy issues and practices. . . . I started working in the Federal Government . . . and then I

moved to the provincial government . . . and responsible for immigration refugee issues.

(PG 1)

Two stakeholders are government officials, one at the federal level (MP) and the other at the provincial level (MPP), involved in the Ministry of Health and/or the Ministry of Immigration and Citizenship.

3.2 Policy maker and Government official Position

The majority of stakeholders from the policy maker and government official category (4 of 5) have concerns about the 2014 IFHP reforms. Two stakeholders opposed the reforms for the reason that in their perspective, the federal government did not restore the pre-2012 IFHP health insurance and instead did the "bare minimum" in terms of reinstating services for refugees and refugee claimants in Canada:

When the court was ruled against the federal government's decision and the federal government did bare minimum, I thought they had to do to honor the letter of the ruling as opposed to the spirit of the ruling which again caused even more confusion, because it added other distinction on who is eligible and who was not. And you know the current effort to go back to court may or may not be successful in terms of how the federal government will respond to it, so I think the federal government is acting unconstitutionally. (PG 1)

I still think the government is doing the bare minimum according to the court as opposed to doing the right thing. And offering health and health care to the people who arrived in this country at face value they should be treated as human beings with obvious health needs particularly in the situation that they have been coming from and fleeing - I think

it's ridiculous that we will go and help people in camps somewhere overseas but we won't help them when they come here. (PG 2)

Moreover, the negative health impacts associated with the limited healthcare provisions for certain refugees and refugee claimants following the 2014 reforms was another reason stakeholder's expressed opposition:

So I can fairly say that I oppose all of the recent changes. There have been no changes that I think have been progressive or have any kind of health benefits attached to them. I think all of the changes that happened have had negative health impacts the refugee claimants specifically and I think it's fair to say that even that other types of refugees like government assisted refugees have had negative health impacts as well because of all of the confusion and changes around who's covered with one and it's led to some refugees being denied care even when they're actually eligible for IFH coverage. (PG 3)

[If] there are refugees being denied healthcare services . . . that's not the type of country that you know that I think we should be building I think that if a person is granted Refugee status in the country there is a responsibility that the country has to ensure that a person has access to healthcare which is a Universal right in Ontario and in Canada. (PG 5)

Only one out of five stakeholders in this category refused to comment on his/her position, stating: "I don't have the granular information that I am able to intelligently comment about this" (PG 4).

Additional disadvantages of the current reforms will be discussed and reviewed

thoroughly in the following chapter. Stakeholder characteristics of policy makers and government officials including involvement, interest, position and ability to influence policy implementation based on resources available are displayed in Table 2.

Table 2. Policy Maker and Government Official Stakeholder Characteristics

Policy Makers and Government Officials				
Stakeholders	Characteristics			
	Involvement in the issue	Interest in the issue	Influence resources	Position
Policy Maker 1	Works at the policy, research, and consulting level regarding immigration and refugee policy; Former government official	High-Medium	Medium	Opposed
Policy Maker 2	Government official involved in health (Federal level)	High	High	Opposed
Policy Maker 3	Works at the policy and research level regarding refugee and refugee claimant immigration and health policy	High	Medium-low	Opposed
Policy Maker 4	Works at the policy and public awareness level of immigrant and refugee policy	Medium	Low	Marginal
Policy Maker 5	Government official formerly involved in immigration and refugee policy (Provincial Level)	Medium	Medium-Low	Opposed

Civil Society Organizations

4.1 Involvement of Civil Society Organizations

In this research, six Civil Society Organizations (CSOs) were identified. All six organizations are non-profit with charitable status or funded by Local Health Integration Networks (LHIN) or Law Foundation of Ontario. These CSOs provide counseling, health and

related services and programs, legal services, settlement services and interpretation and information services. Three organizations provide healthcare services:

We see a lot of refugee claimants, people with precarious status... who are not only getting help with physical health issues but also with emotional and psychological problems most of the time because of the social determinants of health so . . . we focus on not just the absence of illness but what it is impacting people's health such as employment, housing, and in this case immigration status and access to health care. (CSO 4)

"I'm the coordinator of [Organization 2] . . . so I'm in charge of all the settlement areas of the refugee claimants . . . and a volunteer clinic with doctors for primary health care" (CSO 2).

I am the executive director of [Organization 6] . . . everything we do at [Organization 6] . . . is for refugee claimants so as part of a process, of course depending on where our clients are in their process, we typically do interact with interim federal health and other very least we interact with them at their initial intake medical which is required.... so all of us on staff deal with a client everyday face to face. (CSO 6)

While the remaining three organizations provide legal and settlement services for refugees and refugee claimants:

At [Organization 3] . . . we provide legal services both in immigration refugee law as well as family law . . . in addition to that there's also counseling support that is provided through [Organization 3] . . . and interpreter services. So in terms of the refugee

community I come into contact with people who have made a refugee claim, have been denied the refugee claim or are somewhere within the immigration process. (CSO 3)

"So I work as a coordinator for the [Organization 1] . . . 20% of the population that we serve are refugees" (CSO 1).

"I am the executive director for [Organization 5] . . . so I'm responsible for the operations of [Organization 5] . . . where we do direct representation of individuals who have refugee issues . . . we also do public legal education and law reform work" (CSO 5).

4.2 Position of Civil Society Organizations

The majority (4 out of 6) stakeholders representing civil society organizations (CSOs) expressed a mixed opinion about the IFHP 2014 reforms, speaking both in support and in opposition of the reforms. These stakeholders expressed support for the program that provides health coverage for vulnerable migrants such as refugees and refugee claimants. However, the reason why many stakeholders opposed the reforms was because the new IFHP program fails to provide all refugees and refugee claimants with coverage, as was the situation during the implementation of the pre-2012 IFH program.

As I said, I do support. It is a system that is for the benefit of our refugees who are coming, if they are claimant, if they are resettled refugees, or if they are waiting for the PRRA and all that. So there are different things that are available but, what I feel is that is does not meet the need of every refugee claimant. (CSO 1)

As noted in the previous chapter, the majority of CSO stakeholders voiced mixed positions both supporting and opposing aspects of the reforms. Despite expressing support for some aspects of the reforms, all four stakeholders denied they would ever demonstrate this support for reasons expertly summed up by CSO 2:

Not really, because what I think is that it's not a favor what the government is doing, it is an obligation that the government has because in the Refugee Convention it says that government has to take refugee claimants or asylum seekers and provide the benefits in the same way that permanent residents and citizens have and in this country we have health coverage where anyone who resides in Canada should have access to health coverage . . . why do we need to still discriminate the population, specifically a vulnerable population. And I don't provide the support because it's not the willingness of the government it's an order. (CSO 2)

In contrast, when asked whether these stakeholders would demonstrate opposition all four organizations mentioned ways in which their actions were promoting healthcare for all refugees and refugee claimants, in opposition to the 2014 reforms that continue to restrict services for some refugees and refugee claimants. Finally, two of the six stakeholders opposed the IFHP 2014 reforms based on the negative health impacts on refugees and refugee claimants:

I oppose the reforms because they are affecting people they're making people sicker and at the end of the day you don't stay because you can lose people all the people can end up in the hospital with more serious issues so at the end of the day you have to provide care. (CSO 4)

Additional benefits and disadvantages outlined by these stakeholders will be analysed

further in the following chapter. Overall stakeholders in this category have mixed opinions on the 2014 reforms expressing both support and opposition and a summary of CSO stakeholders' characteristics are displayed in Table 3.

Table 3. Civil Society Organization Stakeholder Characteristics

Organizations				
Stakeholders	Characteristics			
	Involvement in the issue	Interest in the issue	Influence resources	Position
Organization 1	Provides leadership programs, training and employment opportunities for refugees and claimants	High	Medium	Mixed
Organization 2	Provides settlement services and primary healthcare for refugees and refugee claimants	High	Medium	Mixed
Organization 3	Provides legal services in counseling, immigration, refugee and family law – aid for those who had been denied the refugee claim or somewhere within the immigration process	Medium	Low	Mixed
Organization 4	Provides services such as Primary health care, employment, housing for refugees and refugee claimants	High	Medium	Opposed
Organization 5	Provide legal services directly representing individual clients who are refugees or refugee claimants and provides public legal education and law reform work	Medium	High	Mixed
Organization 6	Provides settlement and integration services for refugee claimants	High	Medium	Opposed

Professionals and Practitioners

5.1 Involvement of Professionals and Practitioners

In this research, six professionals and practitioners (PP) were identified, including physicians, social workers and lawyers involved with refugees and refugee claimants. Two key stakeholders are physicians:

I work with Refugee claimants and refugees in a few different clinical contexts. So I am a family doctor . . . and I work with an organization that allows us to work with various shelters and drop-in centres with this population. (PP 1)

So I work as the director of [Organization 7]... it's a clinic that was created to serve the needs of refugees and refugee claimants so everyone we see here is going through the refugee process the majority of people we see are refugee claimants. (PP 2)

Two key stakeholders are social workers:

"I am a case worker at a settlement agency and I help refugees and refugee claimants on a day-today basis," (PP 3).

I am the settlement counselor at the [Organization 8]... and my role here is to help them pretty much with everything they need to integrate into Canada assisting with paperwork or work permits, filling out healthcare applications for permanent residency and even help with banking or housing stuff. (PP 6)

Finally, the last two key stakeholders are lawyers:

"My involvement is that I represent refugees and refugee claimants of the refugee board," (PP 4).

I'm a lawyer in private practice and I work only in the areas of immigration and refugee law so I represent refugee claimants before the refugee boards and also in their appeals and as well, I have been working on the IFH legal challenge. (PP 5)

5.2 Position of Professionals and Practitioners

The majority of professionals and practitioners (4 out of 6) expressed mixed opinions on the 2014 IFHP reforms, maintaining support and opposition of the policy currently in place. These stakeholders expressed support of the existence of a program that restored some services for refugees and refugee claimant, including drug coverage and basic coverage for pregnant women, expanded full coverage for children and the removal of coverage based on country of origin. However, support would not be demonstrated because the program in place was an order by the federal court that did not restore all services to all refugees and refugee claimants:

I support the expansion of coverage for pregnant women and children. I support the removal of coverage on the basis of country of origin. . . . I don't demonstrate this support for the reforms at all because overall I still don't support the way that they've done things, they've done small piece meal things but overall there's a huge problem so what I would demonstrate is a lack of support for the way that they have done things. (PP 1)

But I would not demonstrate this because I think that they [policy makers] had no choice because like people were voicing concerns and it's not like they said, "You know what I didn't realize the severe impacts let's just fix this." I mean it took a court case and they were ordered by the court I mean the treatment was found to be cruel and unusual, cruel and unusual treatment. (PP 5)

Additionally, one stakeholder expressed support for the program on the basis that healthcare coverage for this population was draining the country's financial resources:

But you also have to think you know that you know the refugee claimants is really a financial drain to the government that took a lot of the budget from the government funds but what I'm trying to say is we really have to help those who really need help meaning only the genuine refugee claimants. (PP 3)

In contrast, two out of six stakeholders opposed the 2014 reforms completely without expressing any support:

Well, basically, what they've done is that they reduce the coverage. I think that is what I am opposing and objecting to. And you're doing that to people who are desperate, people who are marginalized because most of these people come into this country they don't even know the system they're not even working so it's kind of like very difficult for you to find your way around if the government is not willing to help. (PP4)

Three stakeholders would demonstrate opposition and the remaining three stakeholders out of 6 would not demonstrate support or opposition having not yet taken the step towards turning their opinions into actions:

I don't know how I would demonstrate it. It's not that I think that I'm too small for this I'm not an outreach person and on my free time I don't have time so I'm not going to start some action, but to go out and start something, I would not be able to do that. (PP 6)

Overall, four stakeholders maintained mixed position while two opposed the reforms. Benefits and Disadvantages outlined by each stakeholder will be reported and analysed in the

next chapter. A summary of professional and practitioner stakeholder characteristics including involvement, interest, position and ability to influence policy implementation based on resources available are displayed in Table 4.

Table 4. Professional and Practitioner Stakeholder Characteristics

Professionals and Practitioners				
Stakeholders	Characteristics			
	Involvement in the issue	Interest in the issue	Influence resources	Position
Professional 1	Provides healthcare to refugees and refugee claimants	High	Medium	Mixed
Professional 2	Provides healthcare to refugees and refugee claimants	High	High	Opposed
Professional 3	Provides settlement services to refugees and refugee claimants	Medium	Low	Mixed
Professional 4	Provides legal services to refugees and refugee claimants	Medium	Low	Opposed
Professional 5	Provides legal services to refugees and refugee claimants	High	High-Medium	Mixed
Professional 6	Provides settlement services to refugees and refugee claimants	Medium	Low	Mixed

Refugees and Refugee Claimants

6.1 Profile of Refugee and Refugee Claimant Stakeholders

In this research, six key stakeholders from the refugee and refugee claimant (RRC) category were identified. Four individuals received permanent refugee status, but they were refugee claimants within the period of 2012 to 2015. Two of the four convention refugees (RRC

1 and RRC 6) received permanent resident status prior to the 2014 reforms and came from Designated Country of Origins (DCOs). The remaining two individuals with refugee status recently received permanent residency in 2015 and therefore were refugee claimants during the 2014 reforms that took place November 4th, 2014. One of these two refugees (RRC 5) arrived from a Designated Country of Origin and experienced rejected and failed claim decisions from the IRB, eventually appealing through Humanitarian and Compassionate grounds in order to obtain permanent residence. The other individual arrived from a non-DCO (RRC 4). Finally, two individuals of the six key stakeholders are currently refugee claimants, one arriving from a DCO (RRC 3) and the other from a non-DCO (RRC 2). All six stakeholders arrived from 3 different countries of origin.

6.2 Position of Refugees and Refugee Claimants

All refugees and refugee claimants were unfamiliar with the recent changes to the IFHP in 2014 restoring some services to the population and only 2 out of 6 refugees and refugee claimants were aware that their health coverage was called the Interim Federal Health Program. The remaining four refugees and refugee claimants referred to their health coverage as their ID as a refugee claimant. This is a valid response as refugees and claimants are required to show their ID upon accessing healthcare services on which a small inscription of IFHP coverage is located.

Of the two stakeholders who were aware of the IFHP and were informed of the changes during the interview, RRC 4 expressed mixed opinions regarding the recent reforms having difficulty accessing healthcare after the reforms despite having received convention refugee status that year:

I go into these offices with my ID with my photo on it and it was stamped by the Government of Canada with 2015 March as the expiry and, “what's wrong with them,” I said, “look at this,” but they would say no and they would deny me care and I was like but I don't believe this, and so I couldn't get any care of any of the problems that ailed me. I was just so thankful that my child had some form of care because he was born in Canada. (RRC 4)

Another stakeholder expressed mixed opinions on the IFHP 2014 reforms having been a failed refugee claimant at that time and unable to access healthcare for his children:

My daughter was sick and my son and I paid just 40 dollars every visit just for a doctor because if we come we need to pay 40 or 60 dollars, but they gave me the receipts. We bring the paper, the ID and they know it because everything on the computer everything on the system, they say this is not covered you need to pay because you don't have health card, so If I get health card then everything fine. (RRC 5)

The majority of refugees and refugee claimants (4 out of 6) expressed support for the IFHP 2014 reforms because some services were now accessible or less limited than they were before so they did not have to pay entirely out-of-pocket to access medically necessary care.

According to RRC 2:

If it covers some healthcare then of course I support it right, so nobody wants to pay so much money when their sick – they have to pay the bills, the rent and then their medical bills – so yeah of course I support it. (RRC 2)

Overall, four stakeholders expressed support for the IFHP 2014 reforms while two had mixed feelings due to negative experiences with the healthcare system. Benefits and

disadvantages outlined by each stakeholder will be reported and analysed in the following chapter. A summary of refugee and refugee claimant stakeholder characteristics including involvement, interest, position and ability to influence policy implementation based on resources available are displayed in Table 5.

Table 5. Refugee and Refugee Claimant Stakeholder Characteristics

Refugees and Refugee Claimants				
Stakeholders	Characteristics			
	Involvement in the issue	Interest in the issue	Influence resources	Position
Refugee 1	Refugee claimant and refugee since 2014 February; from Designated Country of Origin	High	Low	Supportive
Refugee 2	Refugee claimant since 2011; from Non-Designated country of Origin	High	Low	Supportive
Refugee 3	Refugee claimant since 2009; from Designated Country of Origin	High	Low	Supportive
Refugee 4	Refugee claimant since 2012 and current Convention refugee; from Non-Designated country of Origin	High	Low	Mixed
Refugee 5	Failed refugee claimant in 2012, applied for H & C and convention refugee since 2015 May; from Designated Country of Origin	High	Low	Mixed
Refugee 6	Refugee claimant since 2009 and convention refugee since 2013 December; from Designated Country of Origin	High	Low	Supportive

CHAPTER 6

FINDINGS PART 2: STAKEHOLDER PERSPECTIVES ON IFHP EFFECTIVENESS

Introduction

This chapter presents the perceptions of key stakeholders regarding the impacts on access and provision of healthcare for refugees and refugee claimants since the recent changes to the IFHP in 2014. The number of individuals with either refugee or claimant status has been quite stable for the last decade with slight population fluctuations in Canada. However, there are considerably more refugees seeking asylum around the world today due to the globalization of refugee movements. Thus, the need to resettle refugees who seek refuge in Canada has increased, of which access to healthcare services is a key component. The health and well-being of refugees and refugee claimants are of crucial importance to the economic, social, cultural and political growth of our nation as most refugees and claimants become Canadian citizens or permanently settle in Canada, contributing to our country.

The presentation of findings is organized in relation to the second question: What are the conditions surrounding IFH policy adoption and implementation that impact access and provision in Canada as perceived by key stakeholders? The four stakeholder groups are policy makers and government officials (PG), civil society organizations (CSO), professionals and practitioners (PP) and refugees and refugee claimants (RRC). The perceptions of key stakeholder groups are separated into the benefits and disadvantages of the current reforms. The disadvantages are further categorized into healthcare access barriers: cognitive, financial, structural and socio-political.

Themes within each stakeholder group are presented with exemplars to illustrate findings. Themes are defined as a group of data similar in characteristics that reflect a healthcare access

barrier category within each stakeholder group. Facilitators to access and provision of healthcare articulated by all stakeholder groups will conclude this chapter.

The IFHP 2014 reforms

2.1 Benefits – What works?

Restoration of Healthcare services

When asked about the advantages of the current refugee health policy, stakeholders noted that the clear benefit was the restoration of services cut in 2012 allowing individuals to begin accessing care. Particularly, CSOs highlighted that children received all care: basic, prescription and supplemental coverage, and pregnant women received basic and prescription drug coverage. One of the organizations mentioned this as a benefit, however remained skeptical stating:

I think it probably had an impact on children's and pregnant woman's ability to access health care I don't think we've seen the data to prove that but it makes intuitive sense to me that there will have been an impact. (CSO 5)

Professionals who expressed mixed opinions on the current reforms highlighted that the benefits included the restoration of most services for pregnant women, of all services for children and the equalization of those from DCOs and non-DCOs in terms of receiving coverage.

Well it's good that they have restored coverage for all pregnant women and all children so that's a benefit and the equalization of DCOs with non-DCOS, but they had to it was a court order. It took the court to order the minister to cover pregnant women - that's what it comes down to. (PP5).

Good experiences of some refugees and refugee claimants

Refugees have encountered good experiences with the healthcare system in place that contributes to their support of the IFHP reforms in 2014. According to Refugee 6, upon her arrival to Canada, she was afraid and this fear originated from the fleeing from her homeland, the arrival in a strange new environment and sheer amount of things she needed to do upon arrival. Her initial experiences with the healthcare system were anything but good, however eventually, she was referred to a physician who provided her with the care she needed. The complications of her hysterectomy had been taken care of by this doctor. This family physician was helpful and sent her to different examinations so at the end of the day, there were no issues.

When I started going to agencies, even the doctors' offices and get things done, I was really surprised how nice everyone was and that we were not treated as Romas. I was really surprised because although in [Country A] healthcare is free you have to give the envelope to the doctors under the table in order to treat you better. And here I was surprised how nice everyone was, didn't have to pay and no secret envelopes and no money to be treated good. (RRC 6)

Refugee 1 came from a designated country of origin and had good experiences with the Canadian healthcare system. He arrived in 2011 with his wife, who was diagnosed with cancer in 2012. The diagnosis was after June 30, 2012 when the initial IFHP cuts were in place. Refugee 1 was unaware of the changes and approached the healthcare system:

I went to different places, family doctors, hospitals, because my wife had cancer. So they did surgery on her at other hospitals . . . so the healthcare system – we were satisfied with the healthcare system, everything was fast and good services not like in [Country A]

where you have to wait for months. . . . And here they found her with cancer within one month and they started the treatment right away So we should've paid for chemotherapy, but the hospital know that our income was low and we were on welfare. So the hospital said we don't have to pay for it, and when we had to go for radiations, at that time we lived in Mississauga and we had to go to Eglinton somewhere in Toronto, and the hospital there made arrangements for us to take a taxi so we didn't have to go back and forth, so we never paid a penny –back home it would've been a fortune. (RRC 1)

Overall, refugees and claimants related that the care they received in Canada was remarkable compared to what they would have experienced in the country from which they had escaped. They expressed gratitude for the kindness and caring attitude of physicians and caregivers in Canada's healthcare setting.

Aligned Advocacy

Due to the various changes to the IFHP over the past 5 years, confusion had grown in the field of refugee healthcare to the extent that there was very little efficiency in providing care for refugees and claimants. However, with the 2014 reforms, efforts by interest groups have redoubled to make providers aware of the situation and develop a more effective network of front-line workers who can provide healthcare to this population in a timely and efficient manner, in an attempt to improve their accessibility. Surprisingly, the majority of policy makers and government officials pointed this out as the main benefits or what's working in the current situation right now.

There is now a tightly knit group of people who know what they're doing on this and are able to influence others and policies and you know I think that they are probably always there but now they're more focused and effective I think in terms of explaining what the gaps are and what still needs to be done. (PG2)

One of the unintended wonderful outcome of this is that the refugee claimant community has found supporters in unusual places so the doctors, the nurses, the healthcare providers, have come together they are the ones who are leading to move to charge to overturn this provision not refugee claimants so I think that is really interesting outcome. (PG4)

Moreover, one policy maker stakeholder outlined the efforts of advocacy groups that arose from multiple stakeholder groups and their contribution in coordinating the established network of professionals and practitioners to provide this care:

The only thing that I could think of that would be positive is that there's actually an opportunity for many groups that are working with refugees and refugee claimants on these issues to actually combine around a common cause and I guess this may be doing some good in terms of coordinating and aligning advocacy around healthcare services for refugees and I think it's may be demonstrated through the Canadian doctors for refugee care the group that organizes the day of action on June 18 every year and the fact that there's so many different and disciplinary groups of healthcare providers and advocates and people who work not necessarily in healthcare but have been refugees and refugee claimants you know it's not how you want to be put together to work in an environment

with one another but it's how you are responding to a really negative situation. . . . at least it's kind of provided those opportunities to better coordinate our efforts. (PG3)

The Federal Government Economic Benefit

According to certain stakeholders from the policy and government official category and the professional and practitioner category with the Temporary Measures 2014 IFH program the federal government was still saving money as it did not revert to the pre-2012 IFH program. According to professional 4, "The federal government is saving because they're paying less" (PP4). According to policy makers, "What benefits are there? We save a little bit of money but so little bit shouldn't be worth talking about" (PG4).

2.2 Disadvantages and Barriers— What's not working?

Stakeholders listed a variety of themes (18 themes highlighted in table A and B) condensed into 9 major dimensions regarding the IFHP reforms in 2014 that can be classified as barriers to accessing healthcare. The healthcare access barriers are an adoption and modification of Carrillo et al. (2011) healthcare access barriers model (HCAB). The HCAB model proposes a taxonomy that describes three categories of healthcare access barriers: (1) Financial - refers to affordability of care and health insurance status; (2) Structural - refers to organizational and administrative barriers; and (3) Cognitive - refers to awareness and communication barriers. The limitation of the model is that it focuses on measurable and modifiable determinants of health status, which excludes other social determinants of health. Therefore, this model is modified to include socio-political barriers outlined by Canadian Policy Research Networks (2006) Towards

a Broader Framework for Understanding Accessibility in Canadian Health Care, for the purposes of this study (see Figure 3).

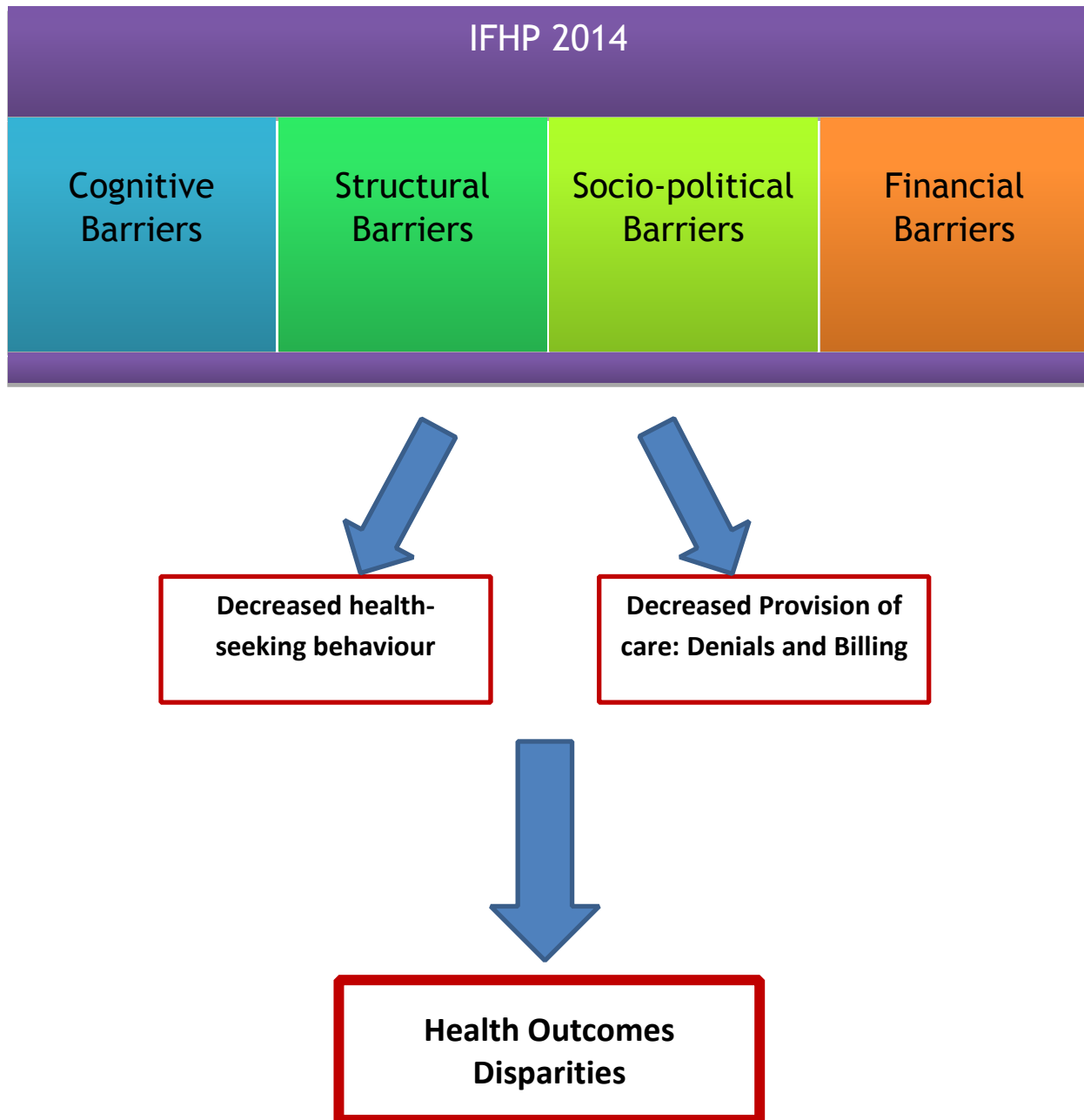


Figure 3. Health Care Access Barriers Model – adapted and modified from Carrillo et al., 2011

The HCAB model in Figure 3 sets healthcare access barriers as units of analysis or themes under which barrier dimensions are identified. This model subsequently provides an approach that focuses on the causal pathways between access barriers and adverse health outcomes by defining intermediary variables as seen on the logic model (see Figure 2): Healthcare access barriers lead to decreased access to healthcare by causing decreased health-seeking behaviour for refugees and refugee claimants. Moreover the healthcare access barriers lead to decreased provision of care by health care providers caused by denying access to care or billing patients. These intermediate effects serve as intermediary measures which ultimately lead to increased health outcome disparities for the refugees and claimant population.

The themed-components regarding the disadvantages or challenges with the IFH 2014 reforms are the following: a) Communication and Awareness of knowledge and information; b) Care Provider training: i) knowledge and ii) billing structure; c) Continuity and Comprehensive Care; d) Affordability: i) of refugees and claimants and ii) of the healthcare system; e) Political Discourse and Public Opinion: Social exclusion; f) Fear; g) Language; h) Location and i) Interaction with the OTHP. The final barrier i) Interaction with the OTHP is perceived by stakeholders as both a facilitator and barrier and therefore, this HCAB theme will be analysed separately. The following themes are classified into their respective healthcare access barrier categories in Table 6:

Table 6. Themes relative to its respective Healthcare Access Barrier Category

Healthcare Access Barrier Category	Theme components
Cognitive	1. Communication and Awareness of knowledge and information
Structural	2. Care Provider Training

Cognitive	a) Familiarity
Financial	b) Billing structure
Financial	3. Continuity and Comprehensive Care (Under- or uninsured)
Financial	4. Affordability (Cost)
Financial	a) Cost for refugee and claimant
Financial	b) Cost for healthcare system
Socio-political	5. Political Discourse and Public Opinion
Socio-political	a) Stigma and Social Exclusion
Cognitive and Socio-political	6. Fear
Structural	7. Language
Structural	8. Location
Structural, Cognitive and Financial	9. Interaction with the OTHP

Barriers perceived by Policy Makers and Government Officials

3.1 Communication and Awareness of knowledge and information

The lack of clear communication on the details of the IFHP 2014 Temporary Measures has confused the masses of healthcare providers according to policy maker and government official stakeholders. They state that with the confusion surrounding the eligibility and coverage criteria, healthcare providers are discouraged from providing care, resulting in denying care to a vulnerable group of people.

All of the confusion and changes around who's covered with one and it's led to some refugees being denied care even when they're actually eligible for IFH coverage....

because health care providers don't want to go through the hassle of trying to determine eligibility. (PG3)

I do know that the health care service community is not clear about what their roles are and so they tend to deny care by default of lack of information. . . . people think it illegal to provide care when in fact it is not, so misinformation.(PG4)

With the adoption of the new Temporary Measure IFH Program on November 4th, 2014, the federal government listed the coverage details on its official website. To date there were no implementation tools or methods to facilitate the uptake of the new 2014 reforms. Thus, lack of implementation is a severe barrier in the current situation leading to a reduction in accessing and providing healthcare for this population. Lack of implementation of the reforms contributed to the continuing confusion initiated from the 2012 cuts as to who is eligible and who is not.

The implementation of the policy seems worse than the actual policy. The implementation has been terrible because there has not been any significant communication that is actually going to the providers or to the refugee lawyers or to the refugees serving organizations or to the refugees themselves, because confusion means that less people will know that they are eligible and confusion will mean that less providers will know what is eligible and therefore the end result will be that refugee claimants will not have access. (PG1).

Most notably stakeholders point out that this confusion stems not only from the federal health insurance plan, IFHP, but also the provincial plans. In 2014, six provinces decided to fund

healthcare services for refugees and claimants to address the gap of periods of non-coverage for this group of vulnerable people, however, stakeholder responses suggest that this plan did not work as intended as healthcare providers become more confused with the eligibility and coverage criteria with two overlapping healthcare plans.

The lack of clarity in terms of who is eligible for what services is quite disturbing. The provider community, the doctors and clinics, the hospitals, have no idea who's eligible for what; understand what they are eligible for and not eligible for. So providers don't know who's really eligible for what federal aid and they really don't know who's eligible for what provincial aid. We have a lot of people who might be eligible for coverage who don't know who they are so they are not seeking it out so they are not getting what they are absolutely entitled to who's eligible to what which has really been in barrier to access both from provider perspective and from a seeker perspective. (PG1)

When the federal government goes on record saying that it will pull its support of the funding of the interim federal health care and then province very quietly says we'll pick it up in places, and we're not only talking about Ontario, then there's an information gap to the health care service providers and refugee claimants themselves who say what's the point going to the doctor if I have to pay for it. (PG4)

Moreover, PG2 emphasized that the lack of information or lack of clear communication resulted in misinformation created barriers for refugees and claimants seeking care because without the correct knowledge. T perceived that refugees and claimants do not attempt to seek

care because they feel reluctant to access a healthcare system that they are unsure will provide them with care:

It seems that there are rumors and misunderstanding that may be there about how the rules keep changing. People don't know what they are entitled to and what they're not entitled to even in the way it is right now so a whole bunch of people may not know that the rules have changed or a lot of people don't know what it ought to be.... that misinformation on what you're allowed and what you're not allowed can sort of fester, such that the people who need help won't seek it because they will be embarrassed and ashamed. (PG2)

Overall, lack of knowledge, lack of information and lack of clear communication for refugees and providers about who is eligible and what is covered leads primarily to denials of care by healthcare practitioners because they are confused by the lack of implementation and do not want to entangle themselves in this complicated system. Moreover, refugees and refugee claimants are deterred by this confusion and therefore, are less inclined to seek help when they need to because they are afraid, ashamed or embarrassed by their lack of knowledge and information on Canada's healthcare system. This confusion is exacerbated by the introduction of provincial plans, as there is no clear communication between the administration of these healthcare plans, the healthcare providers who are required to carry out the utilization of these plans and the refugees and claimants who are meant to utilize these plans.

3.2 Continuity and Comprehensive Care

Although services were restored to eligible refugees and refugee claimants, pregnant women and children, policy makers recognize that many are provided with limited health coverage to this day. Pregnant women do not receive supplemental care, including vision and dental care. Eligible refugee claimants and privately sponsored refugees are underinsured, so they are not covered for medications as well as supplemental care. Ineligible, rejected, failed and suspended claimants and those applying under humanitarian and compassionate grounds are not covered for any healthcare services, except if their condition was a threat to public health or public safety. Many realize that this is an inherent barrier for those who arrive in Canada and providers who provide them with care (PG1, PG3):

"As a provincial government we looked at it as a setback in health care and the support that was being supplied to people with Refugee status in Ontario we disagreed with their decision." (PG5)

The providers are pretty frustrated that this is not the way that they would like to deliver care. I think it's just because there are still restrictions that don't allow them to be able to whether it's provide the medications, provide the kinds of things they need to be able to get people on the path to health." (PG2)

3.3 Affordability

One policy maker stakeholder identified that community health centres are paying for healthcare refugees and refugee claimants eligible to access care under the new reforms because they are being turned away. In Ontario, the provincial government has supplied community health centres with funding to provide services for the uninsured, which includes a variety of

people, such as returning Canadians who are not eligible for OHP for 3 months, new Canadians, and the homeless who don't have an OHIP card. According to PG3,

There's a whole bunch of ways to be uninsured, but what CHC's have been reporting is that they are having to use their small amount of funding for refugees and refugee claimants who may actually be able to access IFH. (PG3)

Finally, many policy makers and government officials recognized the excessive cost of implementation of the IFHP since the 2012 cuts and continuing after the 2014 reforms. According to the vast majority, it will cost the healthcare system much more if refugees and claimants are being denied primary, preventable or treatable care because they will present to the healthcare system late resulting in increased costs for provincial governments to pay for the severely poor healthcare conditions and outcomes of this vulnerable population.

I think it's very short-sighted even from a financial perspective, going to an emergency department is much more expensive than being able to go to a family doctor to get what you need and the amount of money that is involved with the IFHP, and the amount of money that is involved with the program that was considered generous was not that significant and not that great to begin with so we're not saving a lot of money and we're causing real difficulty not only for individuals, but for our healthcare system and for society going forward. (PG1)

"This is a small amount of money that they've cut which can end up costing huge amounts in hospitalizations and all kinds of other things this this makes no sense at all."
(PG2)

"The provinces that have to pick up the health care costs of people turning up uninsured in emergency rooms in poorer health than they could be if they had actually received their services earlier." (PG3)

"The government passing the buck onto the province and passing the buck on to individual health care . . . Ontario is picking up the costs so this is yet another insidious form of downloading." (PG4)

Overall, policy makers and government officials identified affordability barriers for provinces and institutions having to pick up the costs created by the lack of continuous and comprehensive care.

3.4 Political Discourse and Public Opinion

3.4.1 Political Discourse and social exclusion

Much of the public and political discourse around healthcare service accessibility for refugees in Canada has been focused on immigration status and whether refugees and claimants are eligible or are abusing the system as “bogus” refugee claimants. The negative rhetoric is a barrier to their access as it depicts all of them as “undeserving,” “queue-barging” and a “burden” on the country and its resources.

Most policy stakeholders highlight that the negative rhetoric reduces refugee health-seeking behaviour, leading physicians to deny care and promotes poorer health outcomes for the population. The majority of policy makers and government officials interviewed stated that the discourse was falsely accusing refugees and claimants of being frauds:

Part of their discourse is that refugee claimants are bad and resettled refugees are good and refugee claimants are queue jumpers and they are coming here to take advantage of our system. This is part of that whole negative discourse about refugee claimants and that this was just another nail in that particular coffin. (PG1)

The unfriendly landscape created by the policy discourse and media has led Canadians to believe refugees and claimants are getting better healthcare. According to the majority of stakeholders, this idea is false:

The only people being denied are the people who've been found fraudulent or "bogus" . . . this [policy discourse] . . . has portrayed gold-plated, better-than-regular-Canadians-get healthcare. They've been purposely misleading Canadians. (PG2)

I think refugee claimants had a really hard go, especially politically around being framed as "bogus" and not entitled to being here and not having a genuine claim. So I think this kind of a political dialogue and public opinion perspective can be really negative. (PG3)

Moreover, the state can be viewed to implement restrictive immigration and refugee policies in order to display its sovereignty in protecting its national identity. However, in Canada this identity was founded based on immigrations and refugees. "Canada is a nation of immigrants and refugees" (PG4), yet the policy discourse is falsely painting the picture that certain refugee claimants are queue jumpers when in reality

There are two different lines - it's [the discourse] conflating immigration policy and rules with refugee policy and rules on purpose and . . . feed[s] that kind of mean spiritedness

that wants to protect Canada from some you know infusions of people breaking the rules and so they're trying to make it sound like refugees are rule breakers as opposed to legitimate immigrants that wait their turn and come when asked. (PG2)

The negative discourse results in social stigma around all refugees and claimants labeling them as “bogus” without consideration of those that are genuine, discouraging refugees and claimants from seeking help within the Canadian healthcare system.

"I mean it's a program that we should be proud of and instead of that the [political discourse]... is trying to tarnish it as though people are misusing the program and that they're not entitled to it and that they're bogus and you know failed all of these negative words that you know make people feel embarrassed to seek help so that... does affect access (PG4).

3.4.2 Public opinion – us vs. them

Unfriendly landscape is built by perception of us vs. them or othering constructed by Canadian citizens, which is presumably led on by the political discourse and media resulting in the social exclusions of refugees and refugee claimants from integration into the Canadian way of life:

Canadians I feel, feel a little startled when they hear, "Oh really, refugee claimants get access to dental care and I don't," you see so this is the 'me vs. them' kind of debate that happens and we must start from a basis of fact. (PG4)

According to some stakeholders, this notion that refugees are receiving better health care than Canadians is misleading.

Most Canadians do have supplementary coverage through their work place, most all welfare recipients; all those people considered to be unable to financially support themselves are given complete health coverage including drugs and vision care and access to emergency, dental care, etc. To say that Canadians are getting things that refugees don't have is really disingenuous. (PG1)

3.5 Care Provider Training – Knowledge and Billing Structure

These stakeholders acknowledge that many healthcare providers are facing the cognitive barrier of lack of knowledge surrounding the recent reforms as well as the structural barrier of facing a complicated billing system.

"They are confused about who is eligible for what and some of them because of that confusion they are resistant or reluctant to provide services to refugees." (PG1)

"The billing process for actually submitting a claim through Blue Cross who run the program is complicated and annoying so healthcare providers have just decided essentially to stop providing care." (PG3)

Both stakeholders realize the cognitive and structural barrier that is causing professionals and providers to deny caring for refugees and refugee claimants which is a barrier on their ability to access care itself.

3.6 Locations to access Healthcare

Policy makers and government officials also realized the barrier of limited access places for refugees and refugee claimants especially in rural parts of the country:

Most of the clinics for uninsured people for example are really in major centres and not across the whole country so if a refugee claimant ends up in a place where there aren't the services uninsured people they are out of luck, or if there aren't you know family practitioners who are prepared to provide the full suite of services, they are out of luck. (PG1)

Barriers Perceived by Civil Society Organizations

4.1 Communication and Awareness of knowledge and information

Lack of clear communication about the reforms in the form of information and knowledge for refugees and claimants creates a barrier for them to access care creating difficulties when navigating through the healthcare system (CSO2). Many individuals either are not aware that they are eligible for certain services or they don't know where to access services (CSO3). CSO1 relates that "If you don't know where to go, it will be hard... You have to find your own resources. You have to go and find it - and that's the hardest thing." (CSO1)

Lack of communication and lack of awareness contributes to confusion that takes place around the reforms (CSO5). As healthcare providers and refugee claimants are not certain of the eligibility criteria or which category of migrant is allowed to access some services, denial of care or billing is the end result (CSO4).

It is extremely frustrating, especially if someone is in the middle of some sort of treatment for prescription so they go to get their prescription one day and then the clinic

or the pharmacist says, "Oh sorry, sorry, it's not ready till about tomorrow so just come by in the morning." So okay and everything's all hunky-dory, and they come by in the morning and they say, "Oh, you don't have coverage." (CSO6)

Hospitals lack knowledge and information regarding the reforms and are billing patients:

"I think hospitals are not really understanding what's happening even though they [refugees and refugee claimants] are eligible for IFH coverage my clients got billed and it is a matter of going back and working with Hospital Administration..." (CSO3).

During the interview, one CSO mentioned that physicians and healthcare providers were still categorizing accessibility of care based on the individuals' country of origin. Segmentation of services for refugees and refugee claimants based on country of origin was removed from the IFHP 2014 reforms yet this segmentation of migrants still seems to remain,

because of the media attention that was on it, everyone thought that it [the segmentation of migrants based on country of origin] wasn't [removed] so the doctors especially the confusion is great, so the people still think that people are not eligible because of their country of origin. (CSO4)

Organizations recognize that lack of awareness of IFHP renewals is yet another barrier of the current system in place. Many refugees and refugee claimants are unaware how to renew their IFH coverage, specifically, how to make the application and how long they need to wait for the application. They are unaware of the existence of the IFH alone and that it has an expiry date is more of a surprise to them. When their IFH expires, refugees and refugee claimants are

left with no insurance plans for their health. They often realize this expiry upon accessing healthcare services for immediate medical needs only to be turned down from services due to the expiry of their insurance. They are forced to muster what little financial resources they have to seek care (CSO4). Additionally, it was observed by CSO3 that, the clients seen at the organization end up having to wait long periods for their IFHP to renew which leaves them in a position without healthcare coverage for the time in-between expiry and renewal.

If they were in a stopgap between when it expired and when they finally became eligible again . . . they are being billed for that and then they can't work out there payment plans so it's like to me at least, it seems that there is a bit of confusion on the ground in terms of access and renewing emergency services and all that. (CSO3)

Moreover, confusion stems from IFH renewals because of the inefficient way the document is formatted. The IFH document, also known as the refugee's and refugee claimant's ID, has two expiry dates. The first is in big bold letters and indicates the expiry of the refugee and claimant ID itself, while the second is more obscure and in smaller font, indicating that the IFH will expiry within one year. The large font-sized date tells the client that their document will expire in about 2 to 4 years and, having inaccurately assumed this official date of expiry as the one for their IFH, they get confused. As a result, they do not notice that their IFH is expired when they try to access services after one year. As stakeholder CSO4 explains,

A lot of people walk around with that paper but they are looking at the big letters which is the expiry for their temporary status in Canada not the IFH. So a lot of clients come and say I was sent to the specialist and specialist wouldn't come and see me because my paper is not valid - when I say look at the small tiny letters - that's what it tells you, you

came last year and let's say January it has been expired since January because it's only valid for one year was so one month before you have to renew it. (CSO4)

Overall, lack of awareness and communication of information is a major barrier in the current refugee healthcare arena where it hinders access to healthcare by promoting difficulties navigating the system, denials of care or billing by professionals and institutions, and IFH expiries resulting in periods of no coverage for refugees and claimants.

4.2 Care Provider Training – Knowledge and Billing

Healthcare workers and their support administration lack training in the area of understanding the IFHP, which is a significant barrier to providing care to refugees and refugee claimants. They lack training on the logistics of the IFHP such as who is covered and who is not and what services are covered. Moreover, they have been reported to not be trained in the billing process, which deters them from providing care due to its complexities. Finally, as they have not been given the information and training regarding billing and IFH criteria they are more likely to deny care for this vulnerable group or bill clients for using their services, which ultimately is a huge barrier to access of care, by refugees and refugee claimants.

Lack of information and not understanding the complex billing structure are barriers healthcare professionals face when trying to provide care, however if they are untrained in both aspects and do not wish to formally learn these aspects, then this contributes to a significant barrier in the access of care for refugees and refugee claimants.

If service providers, if the people, agencies, were working with refugees, if they don't now, what are the changes if they can't talk about the changes, the workers are not really trained – there is no way for the information to come back. (CSO1)

All CSO stakeholders noted the lack of knowledge and information provided to healthcare workers in the field of refugee health. Many rely on hearsay and are not trained to treat vulnerable individuals who have arrived from difficult situations as refugees and refugee claimants. This lack of training in the healthcare workforce is a major barrier to access care because without being trained, healthcare providers may inappropriately deny care or require payment where none is due.

IFH is the actual problem they were the usual doctors who knew and people would go to them but a new doctor would say I don't know how to bill so I'm not going to see you or I'll see you but I will send you a bill so that happened. (CSO4)

Apparently, the specialist and their offices are inexperienced in the regulations of the IFHP and these healthcare professionals and their support administration are the providers that exhibit the most denials of care and financial stress upon refugees and refugee claimants.

"The people who are more confused sometimes it's not the doctors, the family doctors or the nurse practitioners, they most of the time know, but [it's] the specialist," (CSO4).

4.2.1 Familiarity of the System

Moreover, CSOs express confusion as to why certain healthcare providers deny seeing patients. They have sought to educate healthcare professionals and practitioners, but they have been left with unsolved issues.

We see that not infrequently we have no idea why - we have talked to everyone we can talk to that will talk to us the results we're getting is simply like it's our kind of like it's

our call and that's the decision we've made but they don't explain themselves and we even offered to say it is it because of their country of origin is it because of a certain time frame is it because they have been reported something and they won't answer those questions. (CSO6)

These issues can be attributed to the unfamiliarity of the system caused by the lack of knowledge, information and miscommunication among healthcare providers.

I would say that physicians just thought people were covered as a general message because almost all people were covered previous 2012 - physicians would have assumed that people were covered. One of the big problems after 2012 was that says physicians suddenly assumed that most people were not covered, and even people who should have been covered we're not getting access as there was this huge misunderstanding as to how many people were excluded, and I would feel quite confident in saying that this problem persists. (CSO5)

CSO stakeholders commented on the impact of the IFHP recent reforms and how they provoked unfamiliarity among healthcare providers creating yet another layer of confusion with the recent changes to the IFHP program:

We all know that it wasn't reviewed for so long, that we aren't used to the new system that we keep on doing the same thing and there might be some discrepancies on who is still accessing the healthcare, who has been provided for, so children would be somebody or group of the community that they are not getting all benefits of this new model. (CSO1)

Finally, concern was expressed that professionals and practitioners are not informed which leads to poor information for refugees and claimants who seek information and care from front-line workers. For example, if a claimant approached a settlement worker and that worker failed to provide the claimant with details about her/his upcoming IFH renewal, this claimant would be unaware and face the stress of finding out that her/his IFH is in need of renewal when they next try to access care. This unnecessary stress could be avoided had if settlement workers are prepared to check and explain the situation regarding IFH renewals. As one CSO mentions:

"settlement workers who are poorly trained and they don't look at these little details that they have to be explaining to clients for example about the renewal of the IFH one year after arrival," (CSO4).

4.2.2 Billing Structure

The recent IFHP reforms continue to be exacerbated by the complex billing system in place, which discourages healthcare providers from providing care as they don't receive reimbursements or timely payments after providing care to refugees and refugee claimants.

it is that when you are doing the payments from the federal government to the service providers in my understanding is very long like delayed and all the paperwork and administrative work that you need to do discouraging to the health providers to provide the healthcare - it's just they don't receive immediate payment and it's totally different even though it's the same insurance that provides with Ontario specifically they have a different procedure. (CSO2)

4.3 Continuity and Comprehensive Care

One economic barrier to accessing healthcare services is that the structure of Canada's refugee health coverage plan lacks continuity and comprehensive healthcare. Individuals are not covered immediately when they set foot in Canada. Some who come to Canada have to declare asylum at CIC centres and meet with the CBSA to pass eligibility criteria in order to receive IFH benefits. These interviews can be scheduled within one week or a couple months – until that time, these individuals are not covered.

More and more people is coming to make a refugee claim more and more they're doing the claim in Canada which gives them in one or two months gap without health coverage. Many of them are pregnant women who don't have access to health coverage because they don't have access to the IFH until they make the refugee claim. (CSO2)

CSO 2 explains that most refugee claimants who make a claim in-land within Canada's borders have to get an appointment for an eligibility interview. This interview would be conducted by a CBSA officer who would assess their eligibility on receiving healthcare insurance covered by the federal government. As CSO 2 elucidates,

"before the cuts between the appointment and the eligibility interview they would be covered with IFH - now they are not covered - they are not covered until they receive the eligibility criteria and that is a huge impact," (CSO 2).

Overall, civil society organizations stakeholders concluded that the economic barrier of the IFHP not providing coverage to some claimants waiting for the IFHP eligibility interview was a significant barrier. CSO 2 described that refused refugee claimant do not have access,

people applying for pre-removal risk assessment (PRRA) did not have access, and finally individuals who had not yet received the eligibility approval did not have access to healthcare.

One example of this gap in coverage barrier was related by CSO 6:

Some people have trouble accessing it because they fall into sort of the gray area between the application that they are going to make as a refugee claimant and their actual arrival on Canadian soil and so we have seen that when someone arrives they've got an appointment with you know citizenship and immigration in 2 days but in one day they become seriously ill and hospitalized and one gentleman was in the hospital for a week with no coverage and he didn't have coverage because he never made it to his initial citizenship and immigration interview and so he was falling into that gray area we've had other people like that but not so severe as that one gentleman who came up with a bill for \$20,000. (CSO 6)

4.4 Affordability

4.4.1 Refugee and refugee claimant affordability

Refugees and refugee claimants do not have the economic means to pay for private insurance so the reduction of services through the IFHP has impacted people, not only limiting their access to healthcare, but billing them for services that they cannot afford. The most frequently related example was that of many women coming into the country pregnant and incurring debt related to pregnancy care and birth (CSO2, CSO4).

We just saw a woman she came pregnant 7 months pregnant she came with malaria she was in the hospital for more than a week and because she went to the emergency they put her to the ICU and with all the specialists they're sending the bills, the emergency is

sending the bill, the hospital is sending the bill. Her bill is more or less \$30,000 and she doesn't have a way to pay. (CSO2)

Furthermore, CSO3 related that providers who were denying care told refugees and claimants that they were ineligible. Instead of checking whether or not they were eligible, refugees and claimants were just getting billed for services, and law clinic had to negotiate the bills to reduce financial strain on refugees and refugee claimants

These people just were not eligible and instead of checking into whether they were still continue to be eligible a lot of people were just getting billed for services and we were having to negotiate out the bills so I think there is a direct impact of reduced services. (CSO3)

Most significantly, some individuals are paying for their healthcare despite coverage under the IFHP reforms. Under the 2014 changes, diagnostic tests are covered for pregnant women, children and all eligible refugee claimants. According to one CSO however, despite the coverage claimants, refugees, providers and institutions are not aware of this coverage and thus they are required to pay from their limited pool of financial resources.

In the hospital they have to do the diagnostic tests and they are sending bills to the clients and people don't know that they don't have to pay so they pay but they pay, and how did they pay? They pay through their visa you know they get a loan so people are getting into huge debts and people have to pay interest for that and so you see when they come they are struggling. (CSO4)

4.4.2 Healthcare system affordability

According to these stakeholders, it is more expensive now for provincial governments and institutions to provide care for the refugee and refugee claimant community because the IFHP reforms have discouraged them from seeking preventable and primary healthcare. Instead, with declined health seeking behaviour, this vulnerable group of people end up arriving to the hospital ER with more severe conditions which is costing the healthcare system significantly more.

It is more expensive now for the government and for the Health System because people don't go to see the doctors in prevention, they go and they end up in hospital like this lady with malaria... she came to us a week later on and she was a very sick. (CSO2)

It's sort of put cost on to the province where is previously the IFHP is a federal program the interim federal health care program, the costs has been sort of shifted to the provinces as individuals are seeking emergency health care than very primary preventive Health Care - doctors noted that they were seeing more serious condition showing up in hospitals people were waiting longer to get health care because they didn't want to pay the cost of seeing a doctor just for you know they've noticed an infection or something like that and they could get some preventive care so very serious things are going on. (CSO5)

Overall, affordability of the individual and affordability of the healthcare system are barriers to accessing healthcare services in Canada. The refugee or claimant does not have the financial means to pay out-of-pocket and thus rely on the IFHP 2014 reforms to provide them with care. Due to the limits in coverage and periods of non-coverage and lack of awareness, it is costing the individual and healthcare system significantly.

4.5 Political Discourse and stigma

CSO 3, recognized that there was stigma and social exclusion, a social determinant of health, associated with the negative rhetoric that all refugees and claimants are “bogus” and that they are abusing the system, especially those from designated countries of origin. It provides an unfriendly landscape deterring refugees from seeking care and healthcare providers from providing it (CSO2, CSO4).

There is a negative narrative towards the refugees and still in some even though there was a very good reaction of the refugee care doctors, there is still some stigma towards refugees and that is something that we need to look into. The stigma that is against refugees specifically because the government has been saying that they did the cuts to the IFH not because there is a deficit budget because they keep saying that Canada is too generous, which is not true. (CSO2)

4.6 Fear

Fear of seeking care, fear of being a financial burden, and fear of financial loss is a huge cognitive barrier that is limiting ways refugees and claimants can seek care.

Many stakeholders in the civil society organization category recognized the fear in their patients and clients when approaching the healthcare system and some can relate examples of when this fear acted as a barrier to access care in Canada. For example one refugee claimant was afraid of costing the government:

They think they are here and they are a burden to the government so they don't want to continue [accessing care] even though they may be ill so they won't seek care - I've heard

of a mother who had been at home for I don't know how long and having an issue that could have been resolved - she had a urine infection or something like that for months and months and she didn't want to go to doctor because she didn't want to cost the government. (CSO4)

Moreover, CSOs recognize that claimants are afraid of reporting such illnesses in case it has an impact on their asylum declaration and that if they are ill, especially with a mental illness, it would lead to their deportation:

When they are having problems with mental health they don't seek help because they are afraid that that will impact on their refugee claim so they're going to be depressed or anxious or having panic attacks they won't disclose that and they will not seek help. (CSO4)

Finally, fear plays a factor in reducing health-seeking behaviour among refugees and claimants when they are unaware of coverage criteria. With the current situation, there has been no clear communication of what is covered and what is not for refugees and claimants as well as healthcare providers. This miscommunication has led to refugees and claimants having to pay for access or be denied access altogether. Moreover, with the new reforms, there are still periods in which the refugee or claimant still has no access to care. For example, when they have not had their eligibility interview, when their IFHP expires and they are unaware, when they are refused, failed or appealing on humanitarian and compassionate grounds. Even as accepted refugee claimants and PSRs they don't have access the medication or supplementary care. Thus, there is

a fear that in the circumstance that they do become ill, their illness will likely take a toll on their financial situation, which will ultimately affect their way of living. As one CSO 6 explains:

"There's fear there's a very tangible fear you know I can't get sick or if anything happens to me I'm sunk because they can't afford health care and I can't get it and terrible things are happening as a result of that."

4.7 Language

As many studies have previously indicated that language is a barrier for all newcomers whether they are immigrants, refugees or claimants (Flores, 2005; Naish et al., 1994), this study finds that the lack of language services discourages refugees and claimants to access care. According to CSO stakeholders, the language barrier is significantly large - although some refugees and claimants have high levels of education, others do not and limited years of formal education contribute to the impact of such a barrier. Thus, individuals who cannot speak English, the one of the primary languages of Canada, find it difficult to access services, as they need to find translators who understand their needs and convey them to the appropriate healthcare provider.

4.8 Locations to access care

With the 2014 reforms, some services were restored but refugees and claimants still had a hard time seeking care because there were limited places to receive care from healthcare providers. Civil society organizations highlight that certain organizations deny providing care for refugees and claimants, resulting in limited places to seek care. CSO 1 relates:

For example, I know one refugee claimant and she was in labour at a hospital, and as soon as the doctor found out that she was HIV positive, she was discharged right away. Go find others. This person was told to go find St. Mike's and there is this midwife who's going help you. That's what I mean. She had to go find that place where she could get help, because they wouldn't do it. If one person is doing the work then the workload is all on that one person – it's not shared, it is very hard for them – if there is the waiting list and waiting times. It's just one example with HIV and labour but I think there are many, many more conditions and places where they are going to deny access because of their refugee status. (CSO1)

CSOs also highlighted that organizations and professionals who do provide care are limited in number and in resources. If one healthcare provider is faced with the responsibility to care for all those with refugee status, the fact that there are limited locations for the population to access care is restrictive not only for claimants but the providers as well by limiting their ability to provide care to all who seek it.

As there are few places to seek care, an unintended consequence is that many of these places are bombarded with patients. Community health centres and clinics for the uninsured provide care for uninsured clients and those with limited access to care through the recent changes to the IFHP as described in this research. Many refugees and claimants, even if insured, seek care at community health centres in particular because they were guaranteed no refusals (CSO1). However, with the limited number of such places, the wait times become tremendously long resulting in full waiting lists or closed intakes for certain services such as providing pre-natal care for pregnant women.

There are fewer uninsured clinics that popped up that are volunteer-run and they are only in certain parts of the city so there is high demand for health services that aren't being met... there are few known places around a city that will see you know injured and undocumented people but... there are long waiting lines for those services so that is an access issue there and in terms of pregnant women they have also found often difficult to access community health centres that have long waiting lists and or closed for intakes.
(CSO3)

Furthermore, stakeholders related that community health centres provide only primary care so their ability to improve the health outcomes of all their patients is limited. Many refugees and claimants flee from the endemic violence enduring the trauma of distressing experiences which contribute to poor mental health outcomes (Kirmayer et al, 2011). Places that provide mental health services and counselling are limited in certain areas of Ontario, so community health centres are required to send patients to other clinics but they are turned away.

"There are not many resources for mental health for post-traumatic stress here... for example and I have sent people to other mental health clinics and they bounce-back..."
(CSO4).

For those who need specialist care or therapies that the CHC cannot provide they are required to seek out hospital services and specialist clinics, however these institutions provide limited care or none at all, requiring refugees and claimants who would then be required to present more information – papers, documents and their limited IFHP coverage:

So I was telling you about two clients recently very recently and they are refugee claimants and the woman was diagnosed with ALS and he was diagnosed with cancer of the pancreas but the problem was that at the health centres we can give primary care but then you need referrals for diagnostic tests or for Specialists or for treatments to go to the Cancer Clinic then you need to present more information. (CSO4)

Finally, geographic locations play an important factor in finding places that provide healthcare services to refugees and claimants. In urban areas, with increased advocacy and clinics for the uninsured opened up, refugees will eventually find some avenue of care. However, in rural and more secluded areas of the province and country, access to healthcare is already limited by the few numbers of healthcare providers and healthcare resources in the rural vicinity (Hay et al., 2006). According to CSO 5:

If you are a failed refugee claimant in Toronto there are clinics that have said out loud and advertised ways to offer services but if you are in another town our place where there is not a Clinic then you don't have any access to services and you probably have less access to information about it. (CSO5)

Overall, CSO stakeholders have outlined the fact that there are limited places to seek healthcare for refugees and claimants which is a great burden for this vulnerable community to access care as well as for institutions that do provide care, such community health centres. This structural barrier limits claimant access to specialist and hospital services as well as primary healthcare when there are long wait times, closed intakes or simply no clinics in the area.

Furthermore, the fact that there are limited services strains the provision of health care from those that do provide it.

Barriers Perceived by Professionals and Practitioners

5.1 Communication and Awareness of knowledge and information

Lack of awareness and communication about the IFHP 2014 hinders access making it difficult for refugees and claimants to navigate the system, influencing denial of care by professionals caused by lack of implementation, and increasing IFH expires resulting in periods of non-coverage. Lack of clear information is a barrier for refugees and refugee claimants when trying to navigate the healthcare system. For refugee claimants, "because it says basic coverage they really have no idea what kind of medical procedure or medical service that they can benefit," (PP3).

For refugee claimants, "these Cuts make this program so complicated that there are many people who are insured but they don't understand what they are insured for," (PP2).

People are not aware of what's going on especially with so many changes . . . I cannot name you one client out of these 300 or 400 files that came here and knew that this is their health coverage – so clients are not educated at all... I think once they claim refugee they should be explained what this is. (PP6)

Moreover there has been, "very, very poor dissemination of information and clarity; there still exists a lot of confusion for both refugee claimants and refugee population and amongst healthcare providers," (PP1). To date there are no implementation tools or methods in place to

facilitate the uptake of the 2014 IFHP reforms. This lack of implementation plan is a system barrier contributing to the continuing confusion, lack of awareness and miscommunication among professional and practitioner stakeholders regarding the eligibility criteria of the 2014 reforms to the IFHP.

I have not seen any implementation at all so as someone who follows these things closely - on the day that we know the government was to announce...or not even that we know they were going to announce but when we knew there was a deadline to determine whether or not the government was to repeal the program, that night, pretty well as late as they possibly could, maybe it was 4pm or 5pm, they announced the Temporary measures and they announced it simply by putting it up on their website, that was it. And those of us who were involved shared that information and then there was discussion in the public sphere but none of that was communicated to healthcare providers in any official channel. (PP1)

"So there has been massive confusion from the get-go in terms of the roll-out there has been very little public information you can't go on a website and really understand what's happened," (PP5).

With regards to healthcare providers, "I can probably talk to 15 to 20 explaining IFH and all I see are blank stares and unless you are doing this as a full-time basis it's very hard to understand," (PP2).

Finally, professionals also noticed that expiry and renewals of the IFHP are a barrier in the current system because they are unaware of what's happening regarding the IFHP 2014 reforms itself.

"First of all, they don't know where they have coverage, second they don't know when it's expired and third they don't know how to, or where to renew or that they have to renew it." (PP6).

5.2 Care Provider Training

Professionals and providers provided a lot of insight on the structural barriers leading to workers who are not trained regarding the IFHP regulations, many of which who are unfamiliar with the reforms. Untrained workers do not understand the system and consequentially, they are more likely to refuse to care for refugees and refugee claimants.

There are many Physicians whom I think who try to understand this program that have found it difficult have walked away from it. We deal with Specialists regularly and I can think of more than one that we have been referring to and one guy who we have been referring to for over decade who no longer accepts IFH regardless of whether people are covered or not so you're certainly seeing those problems. (PP2)

Again, professionals, including specialists, continue to deny care or require financial compensation to provide care for refugees and refugee claimants, despite the institution of the 2014 IFHP reforms.

5.2.1 Familiarity

The lack of information for practitioners has been reported to derive from either their unfamiliarity with the system or the billing conditions that contribute to a structural barrier within the system that must overcome. Many stakeholders commented on how professionals and practitioners are unfamiliar with the system and that is a reason why they may seem untrained to deal with refugees and claimants.

Physicians who accept IFH a year ago still are not accepting it now and part of that is although there is increase scope of insurance coverage many people just don't understand it . . . the problem is that for many individual clinicians that type of understanding I think it's quite understandingly, it's not there, I mean they are so complicated, so people often get turned away in private offices, or be asked to sign forms assuming responsibility for financial costs because people just don't get squat on who's not so I think for those who understand it it's a lovely to know that children now have the same coverage that they had in the past, but if you survey a lot of healthcare workers I'd be surprised if they actually understood that. (PP2)

Stakeholder 3 admits that she has difficulty interpreting the coverage set out by the government in the IFHP 2014 reforms.

When they say basic coverage we don't really know what it is it could be also at Hospital admissions we don't know that right and we don't know if it's specially surgery we don't know that so when you say basic coverage my understanding is that a regular doctor visit or if you have minor cold cough or something like that fever. (PP3)

Furthermore, stakeholders in this category attribute the lack of implementation methods and next to no consultation with the medical community when announcing the reforms, which has led to lack of knowledge for physicians who remain unfamiliar with the criteria and billing systems of the IFHP 2014. "Not properly training healthcare workers on the administrative front of billing for the IFHP and not properly education the workers on the criteria the IFHP covers has greatly hindered access to healthcare services for refugees and refugee claimants," (PP1).

According to PP5, the medical community was not consulted before the changes were made to the IFHP in 2012 and because there was no consultation, these initial cuts "blind-sided" healthcare providers. Moreover, the changes to IFHP in 2014 were new, instead of a restoration of the program before 2012, which left providers with no form of resource to figure out how to navigate the system themselves, let alone guide a refugee or claimant through it. As the government did not consult the medical community before announcing this decision and because it was object to secrecy having been placed on the budget bill, not one person was prepared for these changes which impacted refugee access to healthcare (Keung, 2012).

5.2.2 Billing Structure

Many stakeholders in this category allude to a "bureaucratic process" through which healthcare providers submit billing of services to the IFH plan, however, if they refuse to pay for the services based on some of the limits to coverage under the plan, the billing should be submitted to the OTHP along with the rejected IFH billing (PP1). According to PP2, Medavie Blue Cross in New Brunswick is the recipient and adjudicator of IFH and OTHP coverage.

Originally, they solely provided reimbursement for bills submitted under the IFHP, however once the OTHP was launched they assumed responsibility over those bills as well.

Despite being taken care of in the same institution, the policy-makers of the IFH in the federal government "refused to share information with the province so instead of passing it down the hall they would send it back to the physician and the physician would have to send this form, the rejection, the initial IFHP, and the claim form, and send this package back" to Medavie (PP2). If IFH rejected the initial bill, it would take 4 to 6 weeks to receive a response on whether the OTHP would reimburse physicians for providing care. Moreover, the billing process is a structural barrier because there is a "tremendous burden in keeping track of paper" and these unwanted consequences contribute to the reason why physicians are deterred from providing care to refugees and claimants (PP2).

5.3 Continuity and Comprehensive Care

Professionals and practitioners in the field of refugee care recognized that there are gaps in the current IFH coverage, which result in a state of being uninsured or underinsured, an economic barrier for refugees and claimants when accessing healthcare services. These gaps are based on the segmentation of migrants making them eligible to receive access to some services depending on their immigration status. Many professionals believe that having different insurance for different refugees and claimants and their families creates a level of complexity and sense of unfairness (PP2, PP5).

The provision of reduced health insurance for some refugees and claimants is a bewildering prospect for some stakeholders: "These are people who are arriving from other countries and are destitute they have nothing so they are depending on the system to help them

and if the system is cutting them off how else do you think that they can access healthcare?" (PP4).

Professionals and practitioners feel the lack of continuous and comprehensive care negatively impacts the way they intend to provide care:

"Our attempts over the last few years have been trying to see people early and this is why the cuts to health insurance become such a challenge it really becomes another impediment for people who already struggle accessing healthcare," (PP2).

Privately-sponsored refugees are facing limited healthcare coverage upon their arrival in Canada. They are refugees recognized by the United Nations High Commission for Refugees (UNHCR, 2014) yet they only receive basic healthcare coverage in Canada (PP5). This includes doctor and hospital visits as well as diagnostic and laboratory tests (Government of Canada, 2014). If they are in need of prescription medication or supplementary care, they are only provided with these services if their condition poses a threat to public health or public safety. As PP5 relates:

[This category of migrants] includes people from such places as Syria where there is no doubt that people are in need of protection and even those people are not getting medications covered so if somebody is coming from Syria, coming as a privately sponsored Refugee and they have cancer, it's too bad for you, your cancer medication is not covered so that's a huge downside. (PP5)

Refused claimants are uninsured under the IFHP 2014 with no coverage unless their health condition is a threat to public health or public safety. Professionals express concern

because this lack of comprehensive care limits access to healthcare leading to increased morbidity. Furthermore, professionals identify that refugee claimants are legally obliged to reside in Canada until the date of deportation, which makes it unjust not to provide care during that period between refusal and deportation:

Unless, you know, you have a communicable disease like TB you got nothing. For example if you are suicidal you get nothing. You can't even see a doctor and you're here legally - you're not here illegally, illegal people were never ever covered - it's simply that your case was refused and you're still waiting for immigration to deal with you in terms of the next step which would be to make arrangements for you to leave but you are here as part of a system. Those people have no coverage at all even though they are just following the law they are just following step one, step two, step three, and maybe they are at step 3 now but they are not here illegally and yet they have no coverage so if something happens to them, they get hit by a car for example going about their business abiding by the law, they have no coverage for any kind of medical treatment, any kind of medication, any kind of benefits as a result. (PP5)

Additionally, the gap between refusal of claim and deportation date can last a long time:

For some people that can happen within a month or two, or it could be 6 months, 8 months, a long time. So you're in this kind of limbo where you have no coverage and you are here legally just waiting for the next step to happen. I mean it could also be that you put in another form of application which is not a refugee but a humanitarian application for example. That doesn't give you status and that doesn't give you health coverage while you are applying, but you know you're doing everything properly and you're even

applying for some complimentary form of protection andin that case you have a heart attack, you can't even see a doctor because you have no health coverage except for Public Health and Public Safety. (PP5)

5.4 Affordability

Professionals and practitioners emphasize that the recent reforms to the IFHP are financially constricting refugees claimants acting as an economic barrier as many stakeholders interviewed underlined costs incurred by the individual and healthcare system because people are not presenting in the early stages to address conditions that eventually evolve as more complex. (PP2, PP1, PP6, PP5).

One scenario was related to me by PP6 stakeholder. The day I was interviewing her, she met with a refugee claimant who was having problems with his IFH coverage. He and his family arrived from a designated country of origin in 2011 and following the 2012 cuts, unaware to them, their healthcare insurance was limited so they were supposed to pay for basic coverage as refugee claimants – basic coverage includes, doctor visits, hospital visits, diagnostic care and lab tests. This coverage was restored in 2014 by the Temporary Measures IFHP. The refugee claimant received a bill from 2012 for accessing hospital services for his daughter, however, he never knew that there were changes to the program and he thought he was covered – his is covered now but he wasn't covered then – so why does he still have to pay now?

None of my clients are aware of this that their coverage would've stopped.... do they have to pay this bill or not - it's absolutely not fair - it's a huge bill and nobody can pay that. So now instead of paying the hospital bills they have to pay a lawyer. (PP6)

Therefore, the lack of awareness and lack of comprehensive care act as a financial barrier for refugee claimants and the healthcare system according to professionals and practitioners.

5.5 Political Discourse

5.5.1 Public opinion –us vs. them

Stakeholders reveal that the situation of refugees and refugee claimants is most similar to that of low-income Canadians who require social assistance from the Canadian government to survive day-today life.

Not recognizing that refugees and refugee claimants are similar socioeconomically in my opinion to people on social assistance these are folks who generally don't come with a tremendous amount of surplus income that they can use for their health needs and that the Government repeatedly makes the comparison to working Canadians and others don't have insurance for medications it's an unfair one - what we really should be doing is comparing low income Canadians that do have access to supplemental benefits very much as refugees and Refugee claimants should. (PP1)

Refugee claimants should get what low-income Canadians get no more, no less. This whole notion of gold-plated coverage was just a rhetoric... but you know refugees are primarily in debt and they don't have money to pay for health coverage and they get the same as low-income Canadians who's on social assistance so that's what they should continue to get. (PP5)

5.6 Fear

Fear is a theme that emerged briefly among professionals and practitioners. One professional aptly observed that due to the recent reforms fear attributes to declined health-seeking behaviour because individuals are afraid that they will be required to pay for services that they cannot afford.

People just feel that they are not covered so they just don't get medical treatment and their condition worsens they end up at emergency and sometimes at emergency the hospital administration says well sign here because you have to pay privately and they get scared and they leave so I know the doctors have documented cases that have escalated because people are scared to actually go and get treatment. (PP5)

5.7 Language

Language and interpretation has always been an issue, not only for refugees but for new immigrants as well (Flores, 2005), and one of the problems providers encountered in this study is finding a translator who would efficiently interpret what they want to convey. More importantly, language is a barrier for refugee and refugee claimants in the current situation because it limits their ability to understand the IFHP 2014 reforms. The only way refugees and claimants know they receive coverage is through a paper, their ID, on which is imprinted the four key words "Interim Federal health Program" identifying them as entitled to certain services when they walk into a doctor's office. However, one stakeholder brought up a crucial point regarding the impact of the language barrier, "first of all they don't speak English - how can they read what's in there, right – nobody points out the health coverage," (PP6). Therefore, the language barrier contributes

to the lack of knowledge or information barrier that limits their access the healthcare services in Canada.

Barriers Perceived by Refugees and Refugee Claimants

6.1 Communication and Awareness of knowledge and information

Lack of clear information on services and eligibility for refugees and refugee claimants lead to a variety of barriers to access care. In terms of obtaining the Interim federal health Program coverage benefits, refugees and refugee claimants must claim refugee status at a CIC office and be evaluated by a CBSA officer to determine their eligibility for the insurance coverage. One of the stakeholders in this category highlighted that her confusion began from the moment she arrived in Canada – she was not aware that could make a claim for refugee status upon arrival in Canada. This lack of knowledge or information was further exacerbated by an untrained immigration consultant who did not inform her of her right to declare asylum at the airport:

And I was very confused because I didn't know whether I should I apply right now or not.

It's confusing. And I think I was misled ... an immigration consultant who did not tell me that I had the right to declare asylum on the airport - If I had done that I think the situation would have been much more easier for me. (RRC4)

Refugees and refugee claimants experience confusion around the IFHP at the hands of untrained professionals and front-line workers who are the initial point of contact for many newcomers. These untrained professionals provide misinformation on the IFHP, as in the case of

RRC 4, or a variety of information that is incoherent and inconsistent, resulting in massive confusion on the part of refugees and claimants:

"Also another problem is they talk so the information from here to here travels, so it's a miscommunication, false concept ideas because there is so many people – nobody knows but everybody thinks they know," (RRC6).

Regarding accessing care through the IFH program administered by the federal government, refugees and claimants raised the fact that they lacked the knowledge and information sources to guide them on where to seek care, what the IFH is, what it covers and most importantly in their point of view, why they have to pay for some services. In most cases, they just accepted the fact that they were denied care or had to pay for services because that was what the system required them to do. They would not question or concern themselves with the reason as to why this is happening, which led to an overall hesitancy to seek care because it was a financial burden on them. As some stakeholders relate:

"They don't know what's going on – they don't understand anything – they don't know anything about the IFH," (RRC6).

"People don't know why they pay, because first everything is covered and then in 2012 after then everything was paying, it was the system see, I have to pay because I was not refugee and I can't stay," (RRC5).

When I got refused and knowing I had to pay everything myself I just said, "Oh, forget it." I just said, "I'm going to work and pay my own healthcare." I didn't really figure out where I was able to go.... Some people don't go on the internet so they can't find out what they are covered for. Once you are refused, you're like never mind, I'll just go with the flow – IFHP doesn't cover that – for me I don't bother finding out – I'm just going to wait for my status that's it. (RRC2)

Lack of knowledge and information acts as a barrier because it misinforms the patient, refugee or claimant, of what services are covered. For example, one woman (RRC3) stated that her experience with the healthcare system was very positive, and that she had never needed to pay for laboratory tests since she was in Canada in 2009. However, her brother-in-law who had arrived April 2015, passed the eligibility interview in June and received his ID with the IFH coverage on it, was asked to pay 30 dollars for his blood work. They did not recognize that there was anything wrong with paying; they felt that this was how the system worked. They just thought it strange that one had to pay while the other didn't so they mentioned it in the interview, but nonetheless, they never questioned the system. According the IFHP 2014 reforms, eligible refugee claimants are entitled to receive coverage for laboratory tests and therefore, are not required to pay. The lack of knowledge and information of the clients and the misinformation generated by the lab and its providers highlight the deficiencies in the system caused by this cognitive barrier to accessing healthcare.

Finally, lack of awareness of what is the IFHP results in refugees and refugee claimants unaware of making IFH renewals. Due to lack of information and awareness, this population

often fails to renew their healthcare insurance plan in time and is subject to periods of non-coverage, where they have to pay to access services. RRC5 related his experience with IFH renewals:

So the ID was expired and after we need to extension but the extension was like 2-3 months, so it's really hard. My daughter was sick and my son, and I paid just 40 dollars every visit just for a doctor because if we come we need to pay 40 or 60 dollars, but they gave me the receipts. We bring the paper, the ID and they know it because everything on the computer everything on the system, they say this is not covered you need to pay.

(RRC5)

Overall, miscommunication, lack of knowledge and clear information, is a severe barrier for refugees and claimants to access healthcare under the IFHP. Miscommunication among providers deters them from offering services covered under the IFH. This lack of clarity leads health providers to require refugees and claimants to pay for services which are covered by the IFHP. Moreover, lack of knowledge and information on the part of refugees and claimants prevents them from questioning the circumstances of their care or to ensure that they renew their IFH. These factors, lead to declined health-seeking behaviour when refugees and claimants are asked to pay for services or denied healthcare services altogether.

6.2 Care Provider Training

RRC4 related her experience with a healthcare provider, untrained in the aspects of the IFHP, in which she endured a very traumatic experience. A couple weeks having given birth to

her child, she realized her child was unwell and was rushed in to the emergency department. She was told her child had lost 20% of his birth weight and was severely malnourished.

I needed to rush him in to Sick Kids Hospital and I didn't know who are sick kids was I thought it was just another floor for children I did not know how bad the situation is when I saw that there was these people, separate people who came from the Sick Kids Hospital and they brought the stretcher and they took my baby and they were putting in all sorts of wires. (RRC4)

It was there she waited for hours and was finally able to speak to a healthcare provider who informed her of the reason why such a misfortune came about:

They realized that your doctor has misinformed you. We need your doctor's contact and your address and her telephone number she had done a really big mistake and we want you to not to go back to her again and I asked why what has she done they said that she had a follow up check- up one week after the child's birth and the signs are telling us that she saw the uric acid crystals and that he was getting dehydrated and that was an alarming sign it was a red flag she should have informed you but she didn't. (RRC4)

Whether this was lack of training, stigmatization or another issue, RRC4 perceived stigmatization and conveyed that it resulted in dire consequences to herself and her child. Thankfully, her child eventually recovered, but RRC 4 reported that she could never forget such an experience with the Canadian healthcare system.

6.3 Continuity and Comprehensive Care

Refugee and refugee claimant stakeholders have experienced a lot of challenges with their healthcare coverage plans due to periods or gaps without healthcare insurance. This lack of continuity and comprehensive care is a financial barrier for this population because it hinders them from accessing care, requiring them to pay for much needed services.

One refugee described the experience of receiving her OHIP card for the first time as “like getting a visa.” However, after the arrival of the OHIP card, she received a letter describing that there were problems processing her health card and she wouldn't be able to access care through the card for one year. Moreover, when she needed to access healthcare, the clinics noticed her IFHP was expired. She was now required to pay for diagnostic tests and lab tests with facilities sending her invoices in the mail.

Another refugee described his situation when he was a refugee claimant and was refused and then became a failed claimant after appealing. He was forced to consider applying for humanitarian and compassionate grounds to remain in Canada. The humanitarian and compassionate application is when the person already tried to apply in all the categories and this person doesn't qualify that is the only application to apply. Once the individuals and his family were deemed failed refugee claimants his whole world spun around and he described his difficulties as such:

So at that time we was not refugees, we was nothing, it was like we was floating, like we waiting the paper, we waiting what they saying, and after pushing again we waiting the process, it's really hard... we can't pick up the welfare, nothing so, we were working, working, we went to the doctor we had to pay like 40 bucks, with the paper certificate we had to pay all that. (RRC5)

The inability to access care during certain periods is a barrier put in place within the confines of the IFHP that needs to be rectified to reverse such difficulties faced by refugees and refugee claimants.

6.4 Affordability

The financial barrier of lack of insurance and comprehensive care is significant in refugee and refugee claimant access to healthcare in Canada. Without health insurance or limited health insurance, they are required to pay out-of-pocket for services that they need to access, especially when they are in an emergency. One refugee stakeholder relates her experience with the healthcare system when she was giving birth and the resulting financial burden she carries to this day:

After exactly one month the time had come, my water had broken, and I went into the emergency section of the trillium hospital at Mississauga and I was seeing the OB and she said I need to fill out the forms. I need this amount and that amount and I said yes, I understand - I have some money not all of it – but I will be paying because I am in the middle of my refugee claim. I remember the paper work was very, very stressful – they said I had to pay 2500 just to stay in the room per day that's not including the procedure, the IV the everything, it was all number and number and numbers... I remember it coming down to 8000 plus dollars. (RRC4)

6.5 Social exclusion and stigma

One refugee claimant related her experiences of social exclusion and stigma upon her arrival from [Country A]. She was referred to a doctor who spoke her language. She reported that this doctor treated the refugee claimant and her family the same way they were treated in [Country A]. “They were looking down on us at that time when we found that family doctor... and I was scared to ask anything or tell them that I had a problem because they were already looking down on us,” (RRC6). She was in a vulnerable position having experienced the trauma from her former homeland, so she was afraid to ask the doctor for anything or even disclose the health problems she was experiencing. “They make sure I don't ask anything... I was happy to get the pills that I needed to reduce my blood pressure that I needed,” (RRC6).

6.6 Fear

Refugees and refugee claimants experience fear upon arrival in a new country as their surroundings are no longer familiar. They have just escaped from danger and are still uncertain that they are safe because they fear that the host country will refuse them entry and deport them back to the difficult circumstances from which they had the courage to flee. One refugee claimant was relating her experience with the healthcare system and depicted this scene upon retelling the events of the birth of her child:

I remember they said congratulations and they put him in my arms and I couldn't feel a thing I didn't have that happiness. It's that the one moment in a woman's life that you're so happy for the safe arrival of a life because obviously for me that life was important I had been through so much for this soul but I was like oh no there's more to come and I was so stressed out... I know I needed so much care but I need to leave because the bills are so high. I couldn't pay the full amount so I paid \$1500 and told them that I would pay the

rest in monthly installments. I couldn't tell them that I didn't have the money because I was scared; they are such a big public figure and hospital I didn't know what they would do with me and my child and I was scared maybe they might just go to the refugee Commission and say or maybe it will impact my refugee claimant hearing or something like that. (RC4)

The majority of refugees and refugee claimants interviewed related that fear of their new environment and the factors that could go wrong in their refugee claim deterred them from seeking healthcare. Some were afraid because they had been rejected and accessing healthcare was a severe financial strain. Moreover, others felt fear of the health provider community. One refugee claimant related that, "I was really scared . . . in the beginning I would not make eye contact . . . at home I would look at the floor and that why I no ask for help, because of very bad experience" (RC6).

Therefore, fear is a cognitive barrier that is present in the lives of many newcomers, such as refugees and refugee claimants. With the misinformation and the periods of non-coverage, refugees and claimants fear to access the system because of financial burdens or a negative impact on their claim.

6.7 Language

Refugees and claimants themselves have identified that the language barrier is an issue that discourages their access to healthcare services within Canada's healthcare system. "It's really hard to make communications and something, it's really hard to explain something and always bring the translator and something, and it's really hard you know," (RC5).

6.8 Location to Access Care

When accessing healthcare services in Canada, refugees and refugee claimants relate that if there are no places to seek care they eventually get lost in the system. For many refugees and refugee claimants interviewed in this study, the fact that there were limited places to seek care greatly hindered access. Places to seek care were primarily reduced due to the confusion surrounding the cuts and reforms in 2012 and 2014 respectively. If healthcare clinics were open to all migrants as they were before cuts in 2012, this barrier would not exist today. Within the context of the reforms, one refugee claimant related her situation when trying to seek prenatal healthcare in Mississauga:

So I unfortunately couldn't get into any of the midwife clinics because my biggest constraint was that first they said I was too late - their bookings were done in advance and number two I didn't understand was for example they said you were from Mississauga but we do have room in the Toronto midwife clinic - I said okay so why don't you give me the contact of that place - they said no, you're not eligible - and I said why? They said because of the area - I said what difference does it make? They are neighbouring cities. They said no because that if once if a person in an emergency situation we recommend not to travel so much and from one place to another it should be the closest possible area. I was frustrated - what do I do? What do I say to her? At that time I really felt like I wish I had knew someone in Toronto - I was so desperate. Anyhow I was turned down from several places. (RR4)

The struggle to access care in non-urban centres is drastically present due to structural barriers of the existence of only a few locations where refugees and claimants can access care.

The Ontario Temporary Health Program – Facilitator in Theory, Barrier in Practice

The Ontario Temporary Health Program (OTHP) provides coverage to individuals who have been refused IFH coverage. The program was launched in January 2014 by the Minister of Health and long Term care at the time, Deb Mathews. The intention of the program was to address the gaps in healthcare coverage for refugees and refugee claimants created by scaling back the IFHP (Government of Ontario, MOHLTC, 2013b). In 2014, some services were restored; however, periods of non-coverage still existed. Particularly, the OTHP assume responsibility for the following individuals it deemed eligible for the provincial plan (Government of Ontario, MOHLTC, 2013a):

- a) Refugee claimants from DCOs or non-DCOs whose claims are still pending (including those claims for appeal or review).
- b) Rejected refugee claimants until their date of deportation
- c) Privately sponsored refugees under OHIP – and providing them with access to medications

Participants who have given consent to be a part of the coverage are insured for most services received in a hospital, primary and specialist care, laboratory and diagnostic services provided in Ontario, as well as some medications equivalent to the Ontario Drug Benefit (ODB) formulary (Government of Ontario, MOHLTC, 2013b).

7.1 Policy makers and Government officials

Policy makers and government officials observe that many provinces have come forward to help refugees and refugee claimants after the 2012 cuts and even now with the 2014 reforms where some are still left in periods where they receive no insurance at all. According to one stakeholder,

The fact that their provinces and territories have just decided to pick up the slack and get in because of this misguided decision... the provincial government was prepared to say look, this is a federal job this is a federal responsibility but if they walked away we're not going to let these people suffer. (PG2)

All stakeholders in this category recognize the efforts of the provincial government and commend the OTHP introduction in January 2014, however many share sentiments in accordance with the following stakeholder,

That the province in Ontario came forward to pick up those individuals who were no longer covered by the interim federal health program is quite wonderful but of the two there has been a lack of clarity from the provincial government in terms of what really is covered and what is not. (PG1)

Policy makers and government officials recognize the unintended consequences of the implementing the OTHP without a formal channel of directing information on the program to healthcare and social service providers.

One of the unintended consequences of that is that it has added to the confusion about who is eligible for what because now health care providers as they go through the process of trying to work out the eligibility and they find out that the claimant isn't eligible for

IFH, then they have to go through the same thing with the Ontario program so like that interaction between things is still complicated. (PG3)

Only one stakeholder would not comment about the effectiveness of the OTHP policy intervention.

7.2 Civil Society Organizations

Many civil society organizations recognised the efforts of the Provincial government of Ontario. In their perspective, Ontario has responded to the IFHP cuts in 2012 by launching a program called the OTHP, a provincial health insurance plan for refugees and refugee claimants who are uninsured or underinsured by the IFHP. According to CSO 4, the OTHP helps to fill in the gap in which some individuals are not covered for health for a certain period. "Some of the provinces decided that while people were waiting for their hearing to be heard refugees could get access through the Ontario temporary health program," (CSO 4).

Moreover, stakeholders of the civil society organizations category noted that the provincial government of Ontario has also "given more funding on health coverage with the health centres" (LR - CSO). However, many of these stakeholders felt that despite the good intentions of the province in the formation and adoption of the OTHP to supplement care provided through the IFHP, the implementation of this program was poorly executed.

Refugees could get access through the Ontario temporary health program, the problem with both the program's is that not everybody knows how they work.... people are also confused because there is a lot of conflicting information coming. For one thing we thought after November 2014, by January 2015 there was no problem if IFH didn't cover

then the OTHP would, but even in my own workplace they didn't know I'd to go and talk to the person who makes the referrals and she says, 'Oh no, I'm telling people they cannot go to specialist' and I'm saying 'Why?' 'I'm telling them to wait until they get OHIP.' You know takes a year or two for people to get OHIP and if they need treatment they need treatment you have to send them and then I had to explain to her. (CSO4)

Frontline workers are either not aware of the benefits the OTHP is offering to their vulnerable clientele or they are misinformed of the coverage and who is eligible. CSO 4 further related that the problem with the OTHP is that "it's not working because people don't know how to use it," and sometimes her colleagues would not know how to obtain information regarding the OTHP coverage. They would call a 1-800 number to the provincial government which would then "give you the run-around." The problem when calling these agencies is that providers deal with machines, waiting for responses and as a front-line worker scheduling one hour or half an hour appointments with clients it is nearly impossible to get a hold of someone during that short period of time.

7.3 Professionals and practitioners

Half of the professionals and practitioners interviewed in this study commended the effort of Deb Matthews, the Minister of Health and Long term care Ontario, in the creating of the OTHP for refugees and refugee claimants, the first provincial healthcare plan for this population. However, some stated that although the program was launched with good intentions, it was not very well thought out (PP2). As one stakeholder specifically says,

I think the OTHP is really a good thing - it's something that's supposed to give you access to what you had before the cuts. The problem is its theory versus practice and practice is that it's being used very little just because it's bureaucratically complicated. (PP1)

These stakeholders felt that the OTHP was not very well communicated to them and they are either unaware of the program and its benefits or are discouraged to pursue the application of billing through the program because of the complicated multi-step billing process so they ask for payment directly, or they charge them for the tests.

Stakeholders relate that applying to the OTHP is bureaucratically complicated (PP2) and that most people are unaware of the prospect of using both federal and provincial healthcare plans as there are a large majority of facilities that are not using the program because it wasn't very well communicated (PP1). Moreover, there are gaps within the program itself because there is a three month waiting period for eligible individuals, unless they are children, pregnant or in need of immediate care. Finally, a major limitation for refugees and claimants is that they need to have access to a healthcare provider, practitioner or organization that would provide them with the information necessary to fill out the consent form and apply for the OTHP to begin with. According to PP5,

The waiting period is 3 months... but first you have to be refused IFH that can take a while then you have to apply for this you have to get a doctor to do it so I don't think it's a very accessible system it looks good on paper maybe but the way it plays out is not perfect at all. (PP5)

Overall, many stakeholders from the policymaker and government official, professional and practitioner and civil society organization categories reported that the OTHP was formulated by the provincial government with good intentions. Although in theory the OTHP has been developed well to fill the gaps of coverage for refugees and claimants, in practice it is difficult for professionals and organizations to use the provincial refugee health insurance plan. This difficulty stems from billing complexities, lack of awareness, complicated administrative process to access information, lack of clarity, and continuing gaps in coverage that result in complicated outcomes for service providers and the vulnerable population the program was intended to serve.

Facilitators

8.1 Community Health Centres

Organizations

Community health centres are centres funded by Local Integration Health Networks (LHINs) created by the provincial government of Ontario to provide services for people within the centre's community jurisdiction to provide primary health care services to the uninsured and undocumented members of the community. Half of the civil society organization stakeholders reported the community health centre as a facilitator to accessing healthcare services for this vulnerable population.

Their [the community health centre's] mandate is you don't need to have a health card to be seen by a community health centre. The community health centre will see you but you go to any other place, then everybody will turn you away and I don't think people are aware that and sometimes the beauty with a health centre is that we see not only patients but we see clients so people will have access to doctors, through the doctor they will have

access to mental health and social workers, and lab workers, peer support workers, cultural interpreters. (CSO4)

Thus, CHC's provide not only primary health care services but contain a network with which refugees and refugee claimants can access other services to aid in their process of settlement and health. The civil society organizations interviewed also work with CHC's to provide comprehensive care to refugees and refugee claimants who turn to them for help.

"I know working with the community we rely really heavily on Health Care Centres who are meant for uninsured and undocumented person as well," (CSO3).

One stakeholder, part of a community health centre, explained that she helped refugees and claimants, particularly struggling with the current IFHP reforms, by negotiating the cost of accessing healthcare:

So one of the things that I tell my clients in this situation is that we advocate for them let me try to reduce the amount of the invoice seldom we are successful but I say to them go talk to accounts and make an agreement to pay \$20 a month because that's all you can afford and I know that you want to pay because they keep sending them notices the final notices and then people understand that they're going to be sent for collection. (CSO4)

Professionals and practitioners

Professionals and practitioners highlight the importance of the emergence of clinics focused on providing care to refugees and claimants across the country and their involvement with

promoting the refugee health upon their arrival to Canada. In particular, one stakeholder points out:

We have seen across the country emergence of health care clinics that serve refugees and a few refugee claimants in almost every urban area across the country. I just got off the phone with someone from Halifax who had opened a clinic last month and I think there's a reason for that. Many of us that stumble onto people going through the refugee system, we recognize those unique needs and perhaps even the new ones, knowledge-based, at this condition and would have to become familiar with it. It's very interesting that all these clinics, many of them, grew organically without much or any connection with others across the country, as it was recognized that these needs were there and we're running into them. (PP2)

Therefore, due to the increased need of clinics for refugees and claimants to openly access healthcare, even following the 2014 reforms, the emergence of refugee health clinics has greatly facilitated the access and provision of healthcare for this population in Canada.

Policy makers and Government Officials

The majority of policy makers and government officials recognize the efforts of community health centres to improve the health and well-being of refugees and refugee claimants. Overall, stakeholders report that community health centres offer services to people without provincial healthcare coverage, such as OHIP (PG2), and that they are an important facilitator of access to health care services for refugees and refugee claimants, a decision made by the Ministry of Health Ontario funding these services through LHINs (PG3). However, due to the denial of care

and lack of information in other institutions, community health care centres get overloaded (PG4). Nevertheless, these stakeholders are in consensus that, "the community health centres having uninsured funding, well that's actually a really important thing that exists and it's unfortunate that people who might be eligible for the IFH have to use it," (PG3).

8.2 Settlement Agencies

Organizations

As two of the stakeholders provided settlement services for refugees and refugee claimants, they recognized settlement organization's efforts to promote access and provision of care for refugees and refugee claimants by providing the right information through education such as where to access health services, which doctors will accept IFH coverage and what services they are actually covered for under the IFH.

There's people like us, people like agencies like YMCA, WYMCA, women's shelters...

and they're coming forward with as much education pieces as they can so I think that that's probably an attempt to create some balance or counterbalance on what's going on.
(CSO6)

Professionals and Practitioners

One professional mentioned that, "settlement agencies and services that are there so they can educate their clients," facilitate access to healthcare services (PP6).

Policy Makers and Government Officials

Two stakeholders in the policy maker and government official category recognized the efforts of settlement agencies in explaining and supporting refugees and refugee claimants on what health care services are available. Moreover one stakeholder highlights, that the government of Ontario funds some services provided through these agencies to facilitate knowledge and information uptake by the refugee and refugee claimant population so that they can access healthcare services more easily:

If they go into any settlement service area or group, you know our government funds services. We've taken up a lot of responsibility for their services after there has been Federal cuts and we do that because we want people to know what's going on, we keep investing and differentiating into second languages to get people to the point they can communicate effectively in this country to be able to fight for their rights and to be able to process information, it's something that we believe people need to do and I would encourage anyone [refugee or claimant] to get into an organization and find out what services are there for them to use. (PG5)

Refugees and Refugee Claimants

Finally, refugees and refugee claimants themselves reported that settlement agencies had helped them in renewing their IFH and helped them to seek out where to access healthcare services (RRC1,RRC5). According to one stakeholder, “I didn’t’ really experience problems [with the IFH] and when we did, most of the time we came here [Settlement Agency A] for help,” (RRC1).

8.3 Clinics for Uninsured

Professionals and Practitioners

Some professionals and practitioners highlighted clinics for the uninsured facilitate access and provision of healthcare services for refugees and refugee claimants in Canada following the 2014 IFHP reforms. "Well the goodwill of some of the refugee doctors basically who treat people with IFH, who treat people without IFH - I mean there are some clinics for the uninsured... where I think it's working now," (PP5).

Refugees and Refugee Claimants

Refugees and claimants have reported that finding a clinic for uninsured has greatly facilitated their access to healthcare services. Clinics for the uninsured help refugees and claimants by firstly, not denying them care and services and secondly, by helping to reduce the financial costs of seeking healthcare in Canada:

Eventually through the shelter I was assigned to go to the doctor... in a place called [clinic for uninsured]... and that was the first person who saw me when nobody was seeing me and I was so relieved, she was my first hope. (RRC4)

So it is a relief for me that I'm here (clinic for uninsured), it really helps out. I don't have to worry about the check-ups I'm going to need for my baby, I'm just going to have to worry about okay, I need to pay \$800 when I deliver my baby and that's it. Not \$3000 anymore. I thank god as long as it's not more... so that's it – I'm really happy. (RRC2)

8.4 Demonstrations

Organizations

One civil society organization stakeholder recognized that the demonstrations by advocacy groups, CDRC and CARL, were important in facilitating access to healthcare services for the refugee and claimant population in Canada by promoting the restoration of all services as it was before the 2012 cuts to refugee healthcare.

On June 15th every year the national day of action, I mean we like that and we feel strongly about supporting that because we feel that sort of on a societal hierarchy doctors are probably top of the heap so we figure if doctors are complaining... that's where we should get on board as well. (CSO6)

Policy Makers and Government officials

One stakeholder in the policy maker and government official category also emphasized that the demonstrations by advocacy groups facilitated access and provision of healthcare services for refugees and claimants in Canada by raising public awareness about the issues surrounding refugee health policy and educating professionals who were unaware or misinformed.

The demonstrations that the doctors have put on raises awareness, and it makes it more possible for some other doctors who were not previously aware, and they come forward to agree to provide services that otherwise they may not have. Public awareness is really good. (PG1)

8.5 Friends and Neighbours

Refugees and Refugee Claimants

Refugees and refugee claimants stated that it was very hard to access healthcare services upon arrival in Canada because of the lack of clear information on what services were available. Many found out where to access clinics for the uninsured, settlement services and even family doctors through friends and neighbours. As one refugee recalls, "so, my daughter babysits to a family who was very nice and helpful so whatever information that we needed to know they helped us, and also they gave their doctors name so we could go," (RRC6).

CHAPTER 7

DISCUSSION

Introduction

This chapter provides a summary of the findings, including similarities and differences among stakeholder positions and perspectives on the Temporary Measures of the IFHP 2014, detailed in Chapter 5 & Chapter 6. The discussion will demonstrate what was consistent with the literature with a particular focus on policy adoption and implementation as well as identify limitations and suggestions for further inquiry. The paper will conclude with recommendations outlined by stakeholders regarding the current reforms for researchers and policy-makers in the refugee health policy field.

Summary of Findings part 1

The findings from this study contributed to understanding the impacts of the 2014 reforms to the IFHP on refugee and refugee claimant access and provision of healthcare in Canada. The first major finding of this study addresses the question: What are the positions, interests and influences of key stakeholders regarding the impact of access and provision of healthcare under the new temporary measures to the IFHP?

Almost all policymakers and government officials (PG) had reservations about the changes to the IFHP 2014 reforms due to a number of barriers outlined in the previous chapters. Their ability to influence the reforms varied from high to low. Only one individual refused to comment on his/her position due to inadequate knowledge of the reforms, a barrier in and of itself to accessing healthcare under the current program. The majority of civil society organization (CSO) stakeholders held mixed opinions of the 2014 reforms as they recognized

benefits and disadvantages. Of the four CSOs that held mixed positions, the ability to influence the policy ranged from high to low as they each had a varying amount of resources available to oppose/ support certain aspects of the IFHP: from no resources at all to substantial financial resources aimed to improve health outcomes of refugee claimants as well as contributing to the continued legal challenge against the government decision. Only two individuals in the CSO group opposed the reforms and were able to influence the policy at a moderate level with certain human resources such as volunteers and time spent to advocate against the reforms.

The majority of professionals and practitioners also held mixed positions of the 2014 IFHP reforms as four out of six stakeholders recognized both beneficial and negative aspects of the reforms. These stakeholders displayed moderate to low influence with some or limited resources to spare. Two of these individuals would not be involved in demonstrations of support or opposition, maintaining low influence. The remaining two stakeholders expressed support but would not demonstrate support due to the increased need to reduce health outcome disparities and improve health for refugees and refugee claimants in Canada. Resources included volunteering to provide healthcare to refugees and claimants as well as contributing time to the legal challenge against the Ministry of immigration and citizenship appealing the Supreme Court decision. Two professionals and practitioners strongly opposed the reforms, one expressing a low ability to influence the policy unable to demonstrate opposition while the other individual maintained a high ability to influence the refugee healthcare policy by leading interest groups to oppose the federal government stance.

Finally, the majority of refugees and refugee claimants expressed support for the 2014 IFHP reforms for the reason that they were provided with some publically-funded health care services that they would otherwise be unable to access in their country of origin, from which

they fled. Only two individuals of this stakeholders group maintained mixed positions on the IFHP reforms because of their negative experiences with barriers to accessing care. All refugees and refugee claimants interviewed were highly interested in the IFHP however, many did not know of the reforms made in 2014 or even the exact name of their health insurance plan, continuously referring to the IFHP as their ID. Therefore, the ability of all individuals in this stakeholder group to influence refugee health policy is minimal resulting in a low ability to provide resources in support or opposition of the reforms.

All in all, eight stakeholders expressed mixed positions surrounding the 2014 IFHP reforms stating both disadvantages and advantages in their current situation of accessing and providing healthcare for refugees and refugee claimants. The stakeholders' ability to influence policy ranged from high to low, with four individuals unable or unwilling to demonstrate support or opposition with no resources. Four individuals had some resources, demonstrated opposition and one of these stakeholders had a high capacity to enact change in the refugee health policy arena. Although seven of these stakeholders were aware of the 2014 changes to the IFHP, only four individuals were completely informed regarding the current IFHP coverage.

Eight stakeholders expressed opposition of the 2014 IFHP reforms solely outlining barriers to access and provision of care in Canada. The stakeholders' ability to influence refugee health reform ranged from high to medium-low: Two stakeholders had limited resources to influence current policy, four stakeholders with some resources demonstrating opposition and two stakeholders with high influence as interest group leaders and policy decisions-makers. Although all eight were aware of the existence of the 2014 changes only three were completely informed regarding the IFHP 2014 coverage details.

Only a minority of four stakeholders expressed support for the recent reforms, however among these stakeholders, there was a lack of knowledge on the IFHP and none of the stakeholders were aware that the 2014 reforms took place. Finally, out of all twenty-three stakeholders, only one stakeholder refrained from disclosing his or her position with respect to the current IFHP reforms due to lack of awareness.

Knowledge and awareness of the 2014 IFHP reforms were assessed based on stakeholder answers to the following questions: a) What is your understanding of the Interim Federal Health Program (IFHP)? b) What is your perspective of the recent changes to the IFHP? c) Which aspects of the IFHP recent reforms do you support/oppose? Stakeholder levels of awareness and knowledge were determined by reviewing their answers to these questions and their ability to outline as well as familiarity with the coverage details for the 2014 IFHP reforms. The majority of stakeholders were aware of the 2014 IFHP reforms. However, they were not well-informed of the details regarding the IFHP changes. As a result, confusion perfused among key stakeholders who were purposefully recruited due to their strong relationship with the refugee and claimant population, either being from the refugee community itself, or working for this vulnerable population.

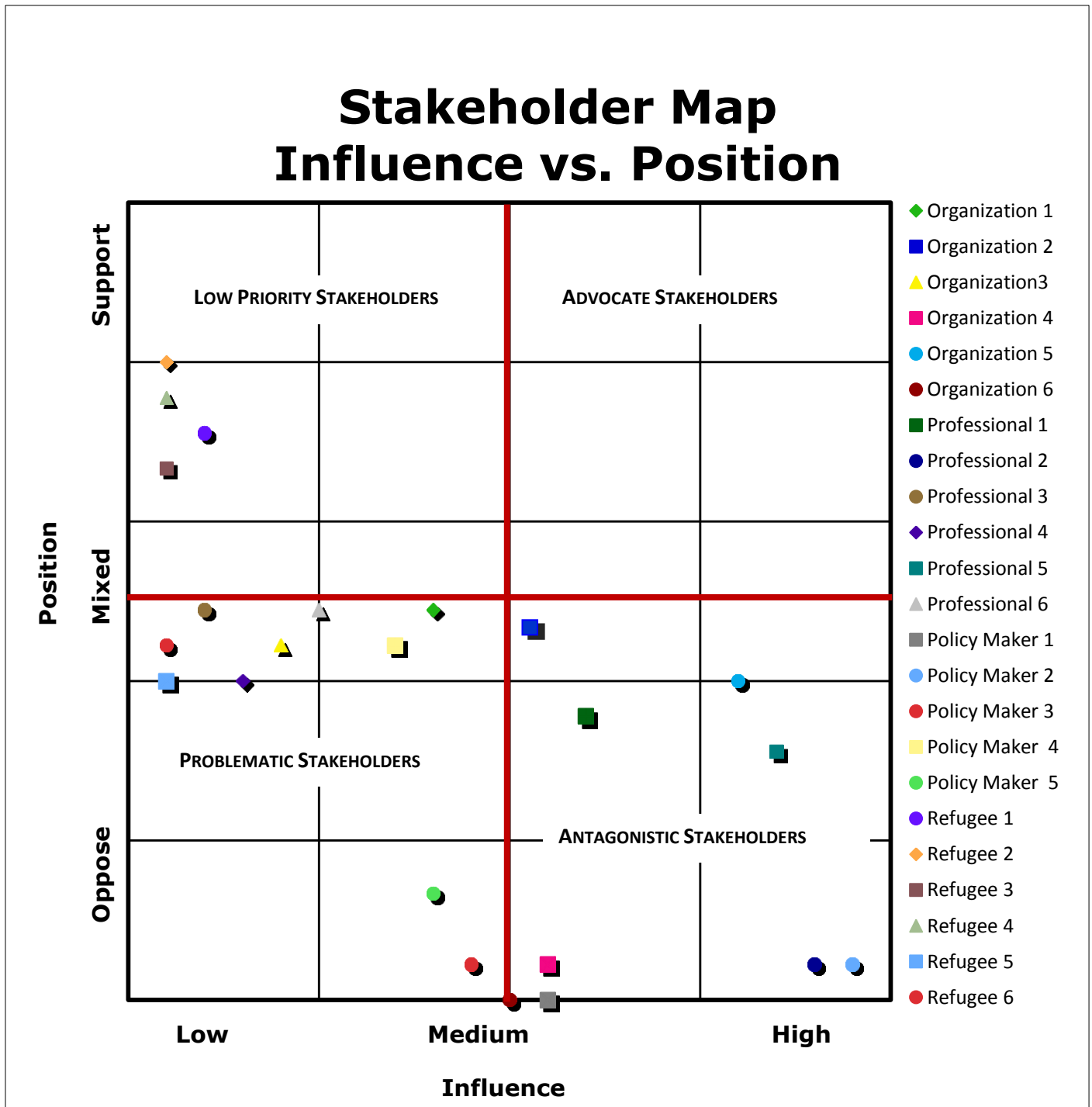


Figure 4. Twenty-three stakeholders are mapped using their position versus their ability to influence Canadian refugee health policy

The stakeholder map (Figure 4) displays stakeholder positions versus their ability to influence to policy. According to Nutt & Backoff, this stakeholder map is used to assess the impact of new strategies through exploring stakeholder positions. The stakeholder map (Figure 4) places stakeholders into one of four categories: low priority, advocacy, antagonistic and problematic. Low priority represents individuals who support the policy but cannot influence it. Advocates are individuals who support the policy and have a high influence over policy decision-making. Problematic stakeholders are those who oppose the policy but do not have enough influence over the policy. Finally, antagonistic stakeholders represent individuals who oppose the current policy and maintain high influence to change it. According to the map, as the majority of stakeholders express opposition or mixed views, with varying levels of influence, the interviewees are classified as problematic or antagonistic stakeholders. The map describes that the pattern of influence by stakeholders sufficiently opposes the IFHP reforms, warranting the reformation of the policy. Moreover, as many of the stakeholder express mixed position it may be possible to "bring on board" these stakeholders by providing them with a role in the decision-making process or incorporating their recommendations or suggestion in developing future policy that is in consensus with the majority of all stakeholder groups (Grundy, 2010, p. 51).

Summary of Findings Part 2

The second major finding of this study reflects the effectiveness of the IFHP 2014 reforms and addresses the question: What are the conditions surrounding IFHP policy adoption and implementation that impact access and provision in Canada as perceived by key stakeholders? Policy formulation and implementation should be based on facts and data, evidence on what works and what fails. New policies and strategies such as the 2014 IFHP

reforms are adopted based on the political and legal ideas and principals of the government and the nation, however, evidence-based policy-making should guide health reform in Canada.

Healthcare in Canada is too costly in monetary value and too important in terms of human necessity to be left in the hands of policy-makers who do not engage stakeholders and obtain the evidence, particularly when providing healthcare to such a vulnerable population of refugees and refugee claimants (Maioni, 2014).

By conducting interviews with 23 stakeholders, this study revealed major findings on the benefits and disadvantages of the recent reforms, particularly the emergence of four healthcare access barriers through stakeholder perspectives, under which 9 dimensions of these barriers were identified. Five facilitators to accessing and providing healthcare in the current situation for refugees and refugee claimants were identified as well. Moreover, five themes were identified as benefits regarding what works or the effectiveness of the 2014 reforms. However, different benefits were outlined by different stakeholder categories. Civil society organizations and professionals and practitioners highlighted that some services were restored for refugees and claimants after the 2012 cuts which helped the IFHP begin to achieve its objective: to improve the health of refugees/ refugee claimants. Refugee and refugee claimant stakeholders revealed that they encountered good experiences with the current healthcare system and coverage. While policy makers and government officials revealed that the benefit of the reforms was the aligned advocacy of key stakeholder groups in changing policy, increasing public awareness and coordinating a more established network of professionals and organizations willing to help refugees and claimants regardless of their status. Finally, one professional and one policy maker noted that with reduced healthcare for refugees and refugee claimants, the federal government is receiving financial benefits by saving money as they are paying less for refugee healthcare.

In contrast to five benefits outlined, the four stakeholder groups identified numerous disadvantages to the adoption and implementation of the IFHP reforms hindering access and provision of healthcare for the vulnerable group of people. These disadvantages were categorized under the taxonomy created by Carrillo et al (2014). The model was modified to include one more barrier category for the purpose of this study as related by the Canadian Policy Research Network (Torgerson et al., 2009). Thus four types of barriers regarding accessing and providing care in the current situation were defined: cognitive, structural, financial and socio-political.

3.1 Similarities and Differences

Analysis revealed that similarities and differences were greater across groups than within groups. The policy maker and government official group as well as the refugee and refugee claimant group consisted of relatively homogeneous responses. Differences within civil society organizations and professional and practitioner stakeholder groups emerged as these stakeholders are primarily the ones who administer the policy and can evaluate the effects. Therefore, they provided varying responses. Similarities and differences among respondents by themes are presented in table 7 and table 8.

Table 7. Similarities among stakeholder perceptions

Similarities of Key Stakeholders' Perceptions by healthcare access Barrier and its thematic dimension		
Barriers	Themes	All 4 Stakeholder Categories: PG, CSO, PP, and RRC

Cognitive Barrier	Communication and Awareness – refugee and provider unaware of the IFHP 2014 reforms	Lack of knowledge for refugees and claimants to navigate the system and their IFH coverage – reduces health-seeking behaviour
		Lack of knowledge and miscommunication for providers leads to denial of care for refugees and claimants
Cognitive Barrier	Care provider training – unfamiliarity	Lack of training due to unfamiliarity with the system led to poorer health outcomes for refugees and refugee claimants because they were denied care or were asked to pay for it
Financial Barrier	Continuity and Comprehensive care – under- or uninsured	Reduced IFHP coverage resulting in uninsured and underinsured refugees and refugee claimants increases health outcome disparities and reduces health-seeking behaviour leading to costs for the individuals, health care institutions and provinces
Socio-Political	Political Discourse – social exclusion	Negative rhetoric around refugee and claimant eligibility to access healthcare socially excludes vulnerable population, reducing health-seeking behaviour, increasing denials of care by providers

As depicted in Table 7, similarities of perception among all stakeholder categories were present in four major themes: Communication and awareness of refugee and provider, care provider training: unfamiliarity with IFHP, continuity and comprehensive care: under- or uninsured and political discourse of social exclusion. All four stakeholder groups related the following cognitive barriers: Lack of knowledge for refugees and claimants to navigate the system and their IFH coverage reduced their health-seeking behaviour. Moreover, lack of knowledge and miscommunication among providers led to denial of care for refugees and claimants. Finally, lack of training and familiarity with the IFH system leads refugees and refugee claimants to choose to delay seeking healthcare because they were denied care or were asked to pay for it.

Furthermore, all stakeholders were in consensus that the financial barrier of reduced IFHP coverage resulting in uninsured and underinsured refugees and refugee claimants increased health outcome disparities and reduced health-seeking behaviour leading to costs for the individuals, health care institutions and provinces. Finally, all four stakeholder groups remarked that the socio-political barrier regarding the negative rhetoric around refugee and claimant eligibility from the political discourse socially excludes the vulnerable population, reducing health-seeking behaviour and increasing denials of care by providers.

Table 8 illustrates the differences in perception between all four stakeholder groups, noting similarities among some groups but not all. Civil society organizations, professionals and practitioners and refugee and refugee claimant stakeholders maintained similar perceptions for the following four themes: Communication and Awareness: IFH Expiry, Affordability: refugees and refugee claimants, Fear and Language Services. All three stakeholder groups related that the cognitive barrier of lack of knowledge and communication regarding IFH expiries lead to increased periods of non-coverage for refugees and refugee claimants, resulting in detrimental health outcomes. The socio-cognitive barrier of fear to seek care and fear of financial loss, attributed to the confusions surrounding the IFHP reforms, created increased health outcome disparities. Moreover, the three stakeholder groups were in agreement that the financial barrier of increased costs for refugees and refugee claimants was deterring them from accessing care, even though they may be covered under the IFHP. Finally, CSOs, PPs and RCs acknowledge that a lack in language services was a structural barrier that affected access in the current situation, impeding communication of the IFHP criteria and expiry dates for refugees and claimants who do not speak English.

Policy makers and government officials, civil society organizations, and professionals and practitioners also had similar perceptions for the following four important themes: Care provider training: billing, Affordability: healthcare institutions and provinces, Political Discourse: public opinion and interaction with the OTHP. All three stakeholder groups highlighted that lack care provider training leads to the structural barrier of the billing process for provider reimbursements which is noted to be a long, bureaucratically complicated procedure. If healthcare providers are not trained about the billing process, they are more likely to refuse care. The three stakeholder groups recognized the socio-political barrier regarding the negative rhetoric from political discourse and its impact on public opinion leading Canadians to falsely believe that refugees and citizens are similar and should not receive extended benefits resulting in refugee social exclusion from healthcare services. These stakeholders argue that in fact, the situation of refugees and claimants is equivalent to low-income Canadians who receive extended healthcare benefits. Moreover, these three stakeholders emphasize that there is a financial barrier of increased costs for healthcare institutions and provinces caused by decreased health-seeking behaviour for preventable or primary care attributed to the continuous changes to the IFHP. Finally, the structural, cognitive and financial barrier created by the IFHP interaction with the OTHP was highlighted among the three stakeholder groups: PGs, CSOs and PPs. The billing complexities, complicated administrative processes to access information leading to lack of information and knowledge as well as gaps in coverage associated with the OTHP over-complicate IFHP healthcare coverage under the new reforms.

Policy Makers and government officials, civil society organizations and refugees and refugee claimants reported similar perceptions on the structural barrier of limited places to access healthcare services. All three stakeholder groups remarked that the limited places to seek care

resulted in overloaded clinics and centres, the limited places to seek specialized care created health outcome disparities among refugees and refugee claimants and finally, limited clinics for uninsured in rural areas hindered access to health care. Civil society organizations and refugees and refugee claimants held similar perceptions on the cognitive barrier regarding provider unfamiliarity with the system in which this lack of knowledge and miscommunication led providers to bill for services despite refugees being covered under the IFHP.

Table 8. Differences in Key Stakeholder Perceptions

Differences in Key Stakeholders' Perceptions by Stakeholder group and Barrier dimension		
Barrier & Theme	Differences in Theme	Stakeholder Group (s) from which the theme emerged
Communication and Awareness – IFH Expiry Cognitive Barrier	Lack of knowledge and communication about IFH expiries lead to increased periods of non-coverage and detriments to health outcomes	Civil Society Organizations Professionals & Practitioners Refugees and Refugee Claimants
Communication and Awareness – Provider Billing Cognitive Barrier	Lack of knowledge and miscommunication propels provider to bill for services covered under the IFHP	Civil Society Organizations Refugees and Refugee Claimants
Care Provider Training – Billing Structural Barrier	The billing structure for provider reimbursements is a long, bureaucratically complicated process	Policy Makers and Government Officials Civil Society Organizations Professionals & Practitioners
Care Provider Training- Specialist office Cognitive Barrier	Specialist offices are most confused by the IFHP 2014 reforms and bill clients for services or refuse to provide care	Civil Society Organizations Professionals & Practitioners
Continuity and Comprehensive Care – Precariousness Structural Barrier	IFHP 2014 places refugees and providers in a precarious situation of unpredictability of being unable to access/provide care	Professionals & Practitioners

Affordability – Healthcare institutions and province Financial Barrier	Decreased health-seeking behaviour for preventable or primary care caused by the continuous changes to the IFH leads to late presentation and increased cost on the healthcare system and subsequently the province	Policy Makers and Government Officials Civil Society Organizations Professionals & Practitioners
	Community health centres are assuming the costs for refugees and refugee claimants despite eligibility to receive healthcare services under the IFHP	Policy Makers and Government Officials
Affordability – Refugees and refugee claimants Financial Barrier	Refugees and claimants suffer depletion of their meager financial resources as a results of confusion around the 2014 reforms that persists today, paying for services that they are covered for by the IFHP	Civil Society Organizations Professionals & Practitioners Refugees and Refugee Claimants
Political Discourse – public opinion Socio-political barrier	Public opinion comparing refugees with Canadian citizens (us vs. them) excludes them as the other limiting their healthcare access which should be similar to what low-income Canadians receive	Policy Makers and Government Officials Civil Society Organizations Professionals & Practitioners
Political Discourse – privatization Socio-political barrier	Healthcare privatization based on neoliberal political ideas is 'tried out' on refugees and refugee claimants resulting on poor health outcomes	Civil Society Organization
Political Discourse – refugees and claimants as scapegoat Socio-political barrier	Refugees and claimants are scapegoats to the economic problems the country is facing	Civil Society Organizations
Location to access care Structural Barrier	Few places to seek care results in overloaded clinics and centres	Policy Makers and Government Officials Civil Society Organizations Refugees and Refugee Claimants
	Fewer places to seek specialized care creates health outcome disparities	

	Limited clinics and centres for uninsured in rural areas hinder access to health care	
Fear Socio-Cognitive Barrier	Fear of seeking care and fear of financial loss attributed to the confusions surrounding the IFHP reforms create health outcome disparities	Civil Society Organizations Professionals & Practitioners Refugees and Refugee Claimants
Language Services Structural Barrier	Limited language services reduces ability to communicate with care providers reducing access to healthcare resulting in refugees and claimants remaining unaware or IFH 2014 coverage and expiry dates	Civil Society Organizations Professionals & Practitioners Refugees and Refugee Claimants
OTHP Interaction Structural-Cognitive-Financial Barrier	Billing complexities, complicated administrative processes to access information leading to lack of information and knowledge as well as gaps in coverage with the OTHP over-complicate IFHP healthcare coverage under the new reforms	Policy Makers and Government Officials Civil Society Organizations Professionals & Practitioners

Finally, individual stakeholder groups brought up barrier dimensions that were different from all other stakeholder categories. Professionals and practitioners remarked that the temporary nature of the IFHP reforms led to the structural barrier of an unstable environment of care for refugees and their providers. Policy makers and government officials highlighted the financial barrier community health centres face as they have to use their limited funds to provide access to healthcare services for refugees and claimants already covered by the IFHP due to the confusion surrounding the reforms. Lastly, civil society organizations identified that the socio-political barrier created by the negative rhetoric in political discourse was a means to use refugees and claimants as a scapegoat for the nation's economic crisis and a trial for healthcare privatization, based on neoliberal values.

Facilitators of access and provision of healthcare in the current situation after the adoption of the IFHP reforms in 2014 were identified by stakeholders under five major themes: community health centres, settlement agencies, and clinics for the uninsured that structurally facilitate access to and provide healthcare, as well as demonstrations that advocate for comprehensive refugee healthcare, and friends and neighbours who provide information on where to access healthcare. The only facilitator perceived among all four stakeholder categories was the usefulness of settlement agencies to provide education for refugees and claimants regarding their IFHP coverage and expiry.

Conclusion: Summary of Results

The analysis of the data was directed toward answering the research questions: a) What are the positions, interests and influences of key stakeholders on the 2014 IFHP reforms?; and b) What are the conditions surrounding IFH policy adoption and implementation that impact access and provision in Canada as perceived by key stakeholders? The findings provided information on the position and influence of key stakeholders: eight were opposed to the reforms, eight held mixed positions, four supported the reforms and one did not comment. Ability to influence policy was evaluated based on stakeholder answers to the following questions: a) In what manner would you practically demonstrate this support/opposition?; b) Do you have financial or human resources available to support/oppose this policy?; and c) Which resources are available and how quickly can they be mobilized? The majority of stakeholders maintained a moderate ability to influence policy, some had limited ability to influence policy, and few interviewed were able to practically influence policy reform. By mapping position and influence of each stakeholder, it

was concluded that the majority of stakeholders were classified as problematic or antagonistic stakeholders, due to the prevalent mixed and opposing positions.

The findings further provided information on the effectiveness of the policy adoption and implementation regarding access and provision of healthcare in the current situation. The four stakeholder groups reported five benefits on what works, five facilitators in the current healthcare environment and eighteen components of healthcare access barriers (illustrated in table A and B) regarding the 2014 IFHP reforms. These eighteen components were condensed into nine overarching themes (Table X) and were further categorized into four health care access barrier (HCAB) categories. The four categories include cognitive, financial, structural and socio-political barriers. Some themes fell into multiple or overlapping healthcare access barrier categories. The nine overarching themes on healthcare access barriers are: Communication and Awareness, Care Provider Training, Continuity and Comprehensive Care, Affordability, Political Discourse, Language services, Fear, Location of Access and Interaction with the OTHP. Of the eighteen components only four were similarly perceived among all stakeholder groups: Communication and awareness of refugee and provider, Care provider training: unfamiliarity with IFHP, Continuity and comprehensive care: under- or uninsured and Political discourse of social exclusion. Only one facilitator was perceived by all groups: the impact on settlement agencies in providing knowledge and education about the IFHP 2014 reforms to refugees and refugee claimants.

Therefore, with the extensive list of barriers identified by 23 stakeholders it is concluded that the effectiveness of the policy is not yet achieved and a reformulation of the policy as well as increased implementation efforts are recommended. Moreover, as there is sufficient opposition or mixed opinion on the IFHP 2014 reforms, a reformulation of policy is needed in

which stakeholders opposing and in support of the policy should be engaged in the decision-making process to incorporate their ideas and develop a policy that is in consensus with the majority of stakeholders for the future.

Relationship of findings with literature and further insights

5.1 Policy Adoption

One of the main emerging healthcare access barrier themes in this study perceived by all stakeholders was the reduced comprehensive care provided by the IFHP in which individuals are uninsured for certain periods of time or underinsured while residing in Canada as a refugee or refugee claimant. This restriction of healthcare services can be seen as a policy response by Canada to the increased mobilization of refugees. Large-scale contemporary globalization, such as the increased mobilization of refugees, has marshalled nations around the world to adjust their mode of governance whereby certain industrialized nations have adopted prevailing neoliberalist regimes that promote government deregulation and privatization (Scholte, 2005). Although globalization of production and financial transactions has diminished state hegemonic control, the emergence of international organizations, such as the IMF, and international law has helped maintain the sovereignty of nation-states. Thus, the development of international refugee policies have empowered nation-states with the flexibility to select which migrants are "extended generous protection" and which are restricted to enter (Basok, 1996, p.141).

Canadian refugee policy has evolved as part of global immigration policy where Canada first joined the international humanitarian efforts to aid refugees during the aftermath of WWII, in which millions of people were displaced as a consequence of war (Basok, 1996, p. 138). Canada stepped to the forefront as the Chair of the newly formed International Refugee Office

(IRO) which has transitioned into the United Nations High Commission for Refugees (UNHCR) today (Basok, 1996, p. 138). During this period, refugees were admitted to Canada on an ad hoc basis until the introduction of the 1976 Immigration Act, which instituted the first refugee determination process for inland claims that continues to be implemented in modern-day policy. The Act explicitly recognizes refugees and refugee claimants as those who seek political refuge or asylum. By signing the internationally established 1951 UN Convention and 1967 Protocol on Refugees, Canada defines a "refugee" as any person who has a, "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country; or... to return to it," (UNHCR, 2010, p. 3).

Throughout the decades, the emergence of transnational asylum seekers shifted refugee programs from those targeted at accepting only European refugees to ones that embraced the entire global population as conflicts erupted from "the East-West tensions to North-South dimensions," (Lacroix, 2000, p. 72). As of the early 1990's, about 100 to 120 million people resided outside their country of citizenship. These migrants included involuntary refugees who were displaced by conflicts in several countries, including Afghanistan, Bosnia and Somalia (Scholte, 2005). The large numbers of people traversing the world as refugee claimants reached a peak flow in 1992 as a reported 700,000 asylum seekers migrated to European OECD countries (Scholte, 2005). Thus, international concerns arose over the massive migration movements which were beginning to be seen as a threat to the sovereignty of nation-states.

The threat of massive migration movements have continued to loom over developing nations, who have disproportionately hosted more refugees over the years, compared to Western

countries that host only a limited number of refugees and displaced persons from around the world (UNHCR, 2014). The West remains a minor destination as the top ten refugee-hosting countries are low or middle income nations to the east sheltering over 57% of the world's displaced population (UNHCR, 2014). Moreover, the refugees hosted by Western countries are unevenly distributed with the majority residing in European countries, 56% of whom are hosted in Germany and Sweden (UNHCR, 2014). Nevertheless, state border controls were implemented to prohibit massive global migrations among Western host countries such as Canada and thus, the globalization that accelerated the free movement of goods and services began promoting the restriction of migrant mobility (Lacroix, 2000).

In Canada, refugee healthcare policy decision-making is a federal responsibility, unlike Canadian citizen's healthcare, which is under the jurisdiction of the province. Prior to the 2012 reductions, refugee claimants and refugees received health coverage under the Interim Federal Health Program that was equivalent to that received by Canadian citizens, with the addition of prescription and mental health services to address pre-migratory trauma (Cleveland, 2012). In 2012, state-imposed restrictions to the IFHP severely limited global movements of refugees into Canada through the stratification of migrants by immigration status and country of origin as well as the elimination of essential social supports, such as healthcare services (Bhuyan et al., 2014). As of 2014 following the order of the federal court to reverse the cuts, the new Temporary Measures to the IFHP was adopted. These reforms restored all healthcare coverage for children, pregnant women receive basic and prescription coverage, general claimants and PSRs receive basic coverage without prescriptions or supplementary care, such as vision and dental care. However, refused, failed and ineligible or H & C appealing claimants continue to receive no care unless their condition poses a public health threat (CIC, 2015).

Refugee policy discourse can be directly attributed to the illegitimate refugee discourse in the political realm that has been prevalent among developed nations for more than a decade (Gale 2004; Mulvey, 2009). This political discourse has been used as a mechanism to develop and implement refugee policy changes in Australia, England and the USA to restrict migrant mobility. Policy frames were adopted to create a negative rhetoric around refugee and claimant legitimacy. According to Entman (1993, p. 52) policy frames are used to influence thinking and policy outcomes through selection and salience. Framing a policy is, "...to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item prescribed." Thus, framing a policy allows policy-makers to define the problem, identify the root cause of the problem, assess moral values and suggest a solution.

Policy makers in developed nations framed refugee and claimant legitimacy as a problem caused by the globalization of refugee mobilization which is regarded as a threat to the nation-state's sovereignty and national identity. Therefore, the solution is to restrict refugee and claimant entry through refugee policy reforms until the individual is determined legitimate. The rhetoric of illegitimacy was employed through political discourse to persuade policy-makers and the public to "change their minds about institutions" by framing refugees as a threat to Canada's sovereignty and national identity and subsequently, creating policy 'solutions' in the form of restrictive refugee policy (Schmidt, 2010, p. 17). This political discourse frames certain refugees as illegitimate or "bogus" in Canada which is derived from the same political discourse in other developed nations, such as the US, UK and Australia, all of which have implemented restrictive refugee policy.

In the United States of America, refugee illegitimacy discourse was used as asylum seekers were perceived as a threat to border security. Due to the USA's serious problem with undocumented migrants, the government imposed increased border security measures to reduce the flow of illegal migrants. As of 2014, 57, 000 unaccompanied children from Honduras, El Salvador and Guatemala crossed the American border illegally, which was double the number of children who arrived in 2013 (Restrepo & Carcia, 2014). Thus America's refugee federal health insurance plan limits accessibility of refugees and claimants by stratifying migrants into categories and does not cover refugee claimants in the process of making a claim or failed refugee claimants. The Cash and Medical Assistance and the Refugee Medical Assistance programs provide health insurance coverage only to those who have been granted a positive decision on their refugee claim (US Dept. of Health and Human, 2014).

The 2014 IFHP reforms in Canada carries out a similar strategy in which failed, refused, ineligible, and Humanitarian & Compassionate applying refugee claimants receive no healthcare coverage unless their condition poses a threat to public health or safety. Moreover, the framing of illegitimate "bogus refugees" in Canada is similar to American refugee framing of illegal migrants. As then-Immigration Minister Jason Kenney stated in response to the federal court challenge by the CDRC and CARL, "... we have no legal, moral, political obligation to give taxpayer services to "bogus" asylum seekers, failed claimants – people who are effectively illegal migrants" (Jones, 2013, para. 8). Thus, both countries use similar discourse to justify restriction of refugee policy, despite the widely acknowledged fact that asylum seekers and failed claimants are not illegal and reside in Canada as part of the claiming process outlined in the 1951 UN Convention.

In England, the “bogus refugee” discourse emerged in the 1990's to dissuade refugee population growth and limit the increasing immigration and race relation tensions (Philips & Hardy, 1997). The negative construction of asylum seekers in political discourse and media framed refugees and claimants as “presenting a risk to many aspects of British life – to employment, welfare and security, and to national values and identity,” (Sales, 2007, p. 6). The rhetoric of 'queue-jumping' and 'illegitimate refugees' led to the New Asylum Model (NAM) strategy in 2005 which introduced a “faster, more tightly managed asylum process,” through the segmentation of migrants into 9 categories as determined by factors such as country of origin (Refugee council, 2006, p. 1). The category to which the refugee or claimant is assigned determines access to levels of social support such as legal aid and housing, length of processing time and placement in immigration detention (Refugee Council, 2006; UNHCR, 2014).

Canada's recent refugee reforms in healthcare parallel Britain's strategy in the segmentation of refugees and claimants based on immigration status, which used to depend on factors such as country of origin as well, in 2012. Nevertheless, even in 2014 migrants are separated into categories that determine access to levels of healthcare coverage under the IFHP. The framing of illegitimate and “bogus” refugees is similar to that in the British political discourse surrounding the justification of introducing restrictive refugee reform. Former Minister of Citizenship and Immigration Jason Kenney stated that, Canada's refugee determination system has been made “faster and fairer” through Bill C-31 (Béchar and Elgersma, 2012, p. 2), similar to England's NAM strategy as refugees from designated countries of origin are restricted under both reforms.

Finally, constructions of asylum seekers and refugees regarding legitimacy, illegality, threats to national identity and border security dominate Australia's political discourse (Gale, 2004; Grewcock, 2009). In particular, throughout Australian history asylum seekers and refugees have been framed as illegitimate to implement restrictive policies, such as introducing offshore processing and mandatory detention of "unlawful non-citizens" from 1989 to 1998 (Grewcock, 2009, p. 120). The non-genuine illegal migrant discourse found in American, British and now Canadian refugee policy can be viewed as originating from Australia's policy framing in which 'boat people' are a threat to security and identity. This frame constructs a dichotomous characterization of the refugee based on their immigration status, distinguishing refugees from camps recognized by the UNHCR as legitimate and asylum seekers arriving by boat to claim refuge in-land as illegitimate.

Canada has adopted this "bogus refugee" framework in its political discourse surrounding the IFHP reforms distinguishing in-land refugee claimants as the "non-genuine" "bogus" individual unlawfully in Canada to take advantage of the generous healthcare insurance plan. In response, policy reform was framed as a solution to "protect public health and safety," from abusing Canada's healthcare system (Government of Canada, CIC, 2012b, para. 1). Therefore following Australia, Canadian political discourse frames the refugee claimant as illegitimate in order to implement restrictive refugee policy decades later.

Canadian refugee policy continues to be influenced by global immigration policy, particularly by the political discourse surrounding refugees and claimants in developed nations. The negative rhetoric frames these individuals as illegitimate or "bogus" resulting in the development of restrictive refugee policies that aim to "protect" against the threat to the nation's

sovereignty and identity. America's eligibility criteria, England's NAM country of origin factor as well as the dichotomous characterization of refugees originating from Australia, influenced Canada's refugee health reforms to the IFHP, resulting in the restriction of healthcare access for categories of refugees and refugee claimants.

5.2 Policy Implementation

The second major healthcare access barrier identified in this study by all four stakeholder groups was the lack of communication and awareness among refugees and providers leading to difficulties for both groups to navigate the healthcare system. The lack of knowledge contributed to care provider unfamiliarity with the IFHP reforms and how to administer the coverage. The lack of information for refugees and refugee claimants led to a decline in health-seeking behaviour because they were told to pay for services already covered under the IFHP or were denied care. The lack of awareness and communication of knowledge and information around the IFHP reform content, eligibility criteria and coverage levels contributed to the immense confusion that diminished the effectiveness as a program to improve health outcomes for such a vulnerable population. This lack of awareness and communication has been attributed to poor or non-existent implementation strategies that should have been outlined by policy makers at the initial launch of this program on November 4th 2014 (CIC, 2014a). The literature on healthcare reform is littered with questions as to why reform avenues remain ineffective. One reason is the implementation of the policy reform itself is seen as "a struggle over the realization of ideas" where politics and administration meet (Majone & Wildaysley, 1979, p. 180).

According to many organizations and professionals interviewed in this study, government policymakers did not attempt to disseminate information on the Temporary Measures IFHP 2014

in any way for the education of providers on the new health care coverage scheme. Instead, the changes to the policy were posted on the Citizenship and Immigration Canada website without any further implementation efforts. As Maioni (2014, p. 4) points out, "institutional contours of the Canada Polity have led to a situation in which publically accountable actors tend to have less of a national reach," compared to non-public actors such as stakeholders who administer the reforms including professionals and organizations. The fact that there is little coordination between governments and key health stakeholders, both consumers (refugees and refugee claimants), and administrators (professionals and organizations) of the policy reform is one of Canada's main challenges with implementation of health care reform.

The impediment to implementation of the current IFHP reforms is the tendency of government policy-makers to disregard health stakeholders, "neutralizing" their influence in policy-decisions. According to Drummond (2014, p. 10), one of the seven conditions found in common with major policy reforms is the collaboration of analysts and stakeholders with the government to "properly frame objectives of reform that will not only be acceptable but also appealing to the public." As seen in the section above, the policy reforms are framed through "bogus refugee" discourse by politicians in Canada. This study reveals that the current policy frame is not accepted by the majority of stakeholders (policy makers and government officials, civil society organizations, professionals and practitioners, and refugees and refugee claimants) and this key finding reflects implementation challenges resulting in ineffective policy reform. Therefore rather than ignoring stakeholder ideas and perspectives, health reform strategies should move responsibility away from the political scene and towards a stakeholder-based model, "extend[ing] the conversation to mindful contributions of stakeholders," (Drummond, 2014; Maioni, 2014, p. 6)

Overall, the lack of political will to coordinate between sectors to generate information and measures to implement and evaluate the performance of refugee health policy across Canada prematurely displays the ineffectiveness of this policy reform (Drummond, 2014). Therefore, a commitment towards data collection, information sharing and evidence-based policy decision making by politicians and health stakeholders alike is necessary for successful reform.

CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

Conclusion

In conclusion, the study fills the current gap in the literature providing knowledge on the effectiveness of the 2014 IFHP reforms. Although some benefits to the recent reforms were uncovered, this study has identified major barriers contributing to the decreased access and provision of healthcare for refugees and refugee claimants in Canada. Overall, the findings of this study suggest that Canada's reforms to the IFHP downloaded refugee health responsibility to provincial authorities and healthcare institutions resulting in bureaucratic strains, inefficiencies, overburdened administration and ultimately, poor health outcomes.

It can be argued that Canada's refugee health policies have transformed from providing humanitarian relief and embracing the notion of nation-building to promoting precariousness and excluding refugees and claimants from the “right” to healthcare (UNHCR, 2010, Article 24 para. 3). In particular, the “bogus refugee” political discourse permeates through developed nations such as England, USA and Australia, consequentially influencing Canada's policy framing of refugees as illegitimate, and as a threat to the nation's sovereignty as abusers of the healthcare system. To suggest that non-genuine refugees are the problem is indeed to seek to avoid as a policy response, our need to stand up to our international obligations and to provide protection to those who need it.

The study reveals that this current policy frame constructed by political discourse is not accepted by the majority of stakeholders. This finding is shown through the stakeholder analysis revealing the prevalence of more problematic and antagonistic stakeholders, including policy

makers and government officials, professionals and practitioners, civil society organizations, and some refugees and refugee claimants, all of whom expressed opposing or mixed positions. As stakeholders disagree with the policy frame and refugee health policy decision makers have excluded stakeholders from engaging in the policy making process, challenges to implementation of the IFHP reform is the end result.

Moreover, these study findings reveal areas for further investigation regarding refugee healthcare in Canada. One future research direction includes assessing the economic impact of the IFHP 2014 reforms through a cost analysis for both federal and provincial refugee health spending to accurately assess how much of a financial drain or gain the IFHP 2014 reforms impose, as compared to the IFHP retrenchments implemented in 2012. Secondly, future investigations on the health status of refugees and claimants through a mixed methods approach, retrospective chart review and qualitative interviewing to analyse context of health status change, from 2011 to 2015 would contribute significantly to refugee health research. This future research would validate whether or not refugee health status has declined after implementation of the IFHP 2014 reforms due to perceived disadvantages and barriers to healthcare access and provision as outlined by this study.

Overall, the study concludes that the identification of a wide range of barriers to accessing healthcare by stakeholders suggests the effectiveness of the policy is not yet achieved and a reformulation of the policy as well as increased implementation efforts are recommended. Moreover, as there is sufficient opposition or mixed opinion on the IFHP 2014 reforms, a reformulation of policy is needed in which stakeholders opposing and in support of the policy should be engaged in the decision-making process to incorporate their ideas and develop a policy in which the majority of stakeholder interests can be taken into consideration.

Stakeholder Recommendations

To assist policy makers to incorporate stakeholder ideas in the future, a list of key stakeholders' recommendations to improve the current situation of accessing and providing healthcare through the IFHP reforms has been generated. These recommendations should be considered by policy-makers in the formulation and implementation of future refugee health policy to facilitate stakeholder engagement. This section will outline recommendations identified by key stakeholder groups:

Policy Makers and Government Officials:

1. Redraft the IFHP to pre-2012 guidelines improving access and provision of healthcare for all refugees and refugee claimants
2. Formulate/ develop IFHP with consultation from providers and organizations at the front-line, aiding refugees and claimants with accessing healthcare services
3. Create a communication strategy for all providers, refugee lawyers, refugee assisting organizations, refugees and claimants that clarifies what the policy is, who is eligible for what services, how reimbursement is administered for providers, accurate information about the rules of the program and how to navigate the healthcare system, identifying places where refugees and claimants can go to seek care
4. Reframe refugees and claimants in the political discourse to discourage biased negative rhetoric
5. Engage members of parliament as a local level to advocate for healthcare access and provision for refugees and refugee claimants

Civil Society Organizations:

1. The Policy should be reviewed and reformulated consulting the refugee health stakeholder community.
2. Inform healthcare consumers and public about policy regulations by providing accessible information; provide pamphlets on coverage at healthcare centres, or an IFH customer contact number that provides language appropriate and simple to use resources.
3. Expand provision of health services from the point of arrival in Canada, in the form of a health card from the time of entry until the date of deportation.
4. Educate consumer population and healthcare providers on the 2014 changes to the IFHP
5. Advocate for the government to restore access and provision of healthcare services to all people in Canada, reducing the negative rhetoric towards refugees and refugee claimants
6. Harmonize expiry dates on the temporary document so that both the IFHP expiry and document expiry are identical.
7. Provide clear guidelines for simple billing and administrative processes. It is recommended by CSOS that if uncertain whether or not coverage will be provided for patient under the IFHP, ask patient to sign OTHP consent form and send that together with the IFHP billing so in case IFHP rejects it, OTHP should cover the cost of services provided

Professionals and Practitioners:

1. Formulate clear policy that promotes universal and equitable access to healthcare that facilitates education and dissemination of knowledge of healthcare coverage.
2. Restore healthcare coverage under the policy to its original structure prior to 2012 cuts
3. Provide the medical, professional and organizational community with nationwide sessions through professional channels or the federal government on how to use the administrative

system, making the billing process less bureaucratic and what the information is regarding the 2014 IFHP reforms

4. Provide the refugee and refugee claimant community with multi-language information from the moment they meet with the CBSA officer for their eligibility interview regarding what they are covered for and where to seek help if confused on how to access the IFHP

Refugees and Refugee Claimants:

1. Same-language personnel are required to educate refugees and claimants on the regulations and eligibility criteria for the 2014 IFHP at the beginning of the process of making their claim in Canada
2. Organizations and professionals in immigration and healthcare should inform refugees and claimants on how to navigate the system through the IFHP and how to renew the IFHP
3. Access to an immigration lawyer is recommended to aid refugees and claimants with their documentation with IFHP and to resolve any financial issues when accessing healthcare

Study Recommendations

In closing, this study recommends the following approaches for refugee health policy formulation:

1. Refugee health reform strategies incorporate stakeholder perspectives, requesting cooperation and leadership from key health stakeholders in order to successfully implement healthcare reform moving from theory into practice.

2. Intergovernmental coordination of policy-makers regulating the Interim Federal health Program and the Ontario Temporary Health Program to reduce bureaucratically complicated administrative processes.
3. National, provincial and key stakeholder coordination to ensure sustainability of the healthcare system for all actors
4. Coherent policy-making focused on evidence (such as that provided by this study) and constant cooperation to facilitate policy-making in a depoliticized environment where governments remain accountable but policy making is protected from negative political discourse
5. Evidence-based policy-making promoting research practices such as data collection on policy effectiveness and implementation, evaluating and sharing this information in the form of public reports on health status and outcomes.

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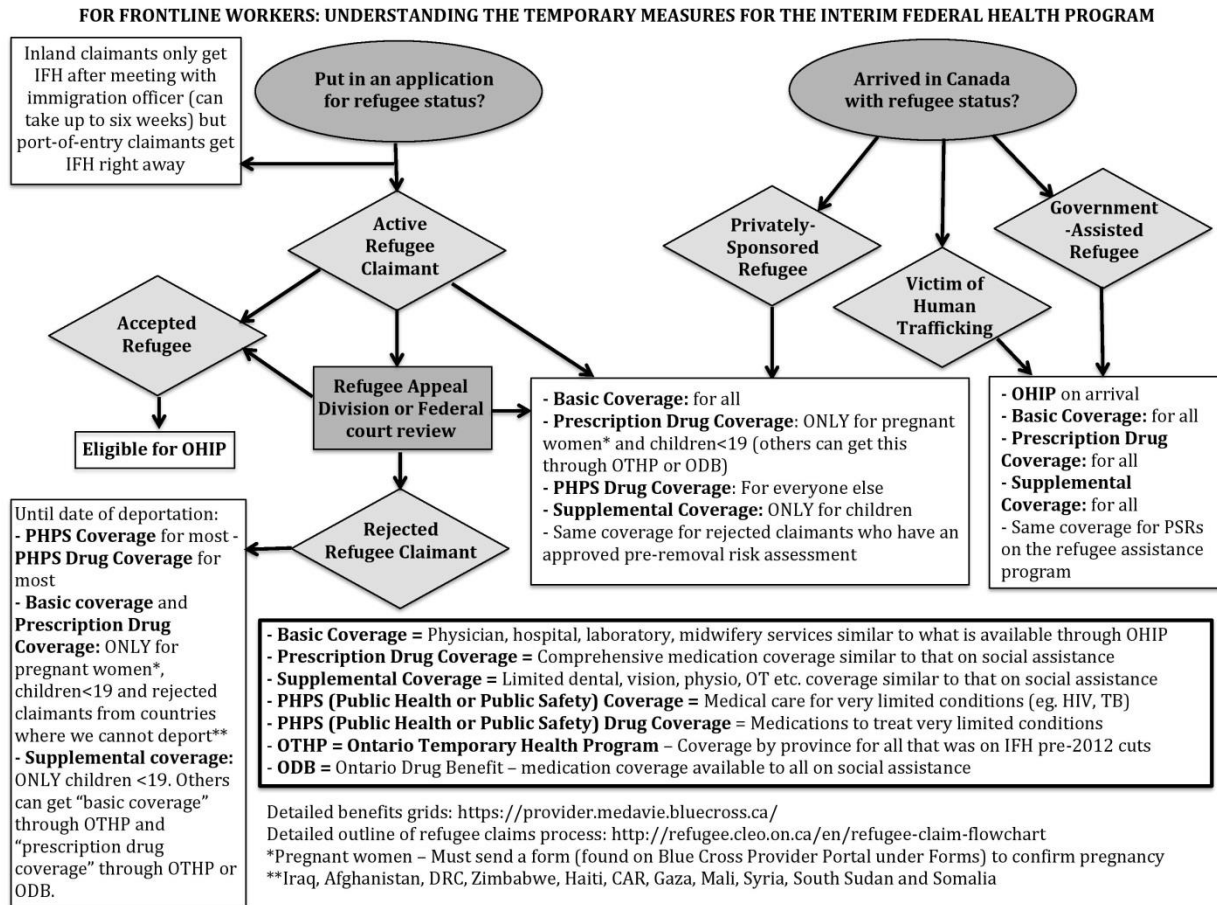
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APPENDICES

Appendix A: Flowchart of "Temporary Measures of the IFHP"



(Source: Goel, 2014)

Appendix B: Letter of Research Ethics Approval



HiREB Student Research Committee

Final Approval

Date:	15 May 2015
REB Number:	15-343-S
Title of Study:	The impacts of the Interim Federal Health Program (IFHP) reforms on healthcare access and provision in Canada: A Stakeholder Analysis
Student PI:	Valentina Antonipillai
LPI:	Andrea Baumann
Version date:	Document:
10 Apr 2015	Application
24 Apr 2015	Protocol Version 2
24 Apr 2015	Consent Version 2
24 Apr 2015	Email Script Version 2
24 Apr 2015	Interview Guide Version 3

Dear Valentina:

We have completed our review of your study and are pleased to issue our final approval. You may now begin your study.

All recruitment and consent material must bear an REB stamp. You may pick up the stamped forms from our office.

Any changes to this study must be submitted with an Amendment Request form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study, please submit a **Study Completion form**.

If you require more time to complete your study, you must request an extension in writing before this approval expires. Please submit an **Annual Review form** with your request.

The Study Completion form and the Annual Review form can be found on our website: <http://www.hireb.ca> and should be sent to Sarah Atkins at atkinsar@HHSC.CA.

Please cite your REB number in any correspondence.

Good luck with your research,

Kristina Trim, PhD, RSW
Chair, HiREB Student Research Committee
Health Research Services, HSC 3H9, McMaster University



HiREB Student Research Committee

The HiREB SRC complies with the guidelines set by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans and with ICH Good Clinical Practice.

Appendix C: Participant Consent Form



LETTER OF INFORMATION / CONSENT

The impacts of the Interim Federal Health Program (IFHP) reforms on healthcare access and provision in Canada: A Stakeholder Analysis

Investigators:

Local Principal Investigator:

Dr. Andrea Baumann
Department of Global Health
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(905) 525-9140 ext. 26631
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Student Investigator:

Valentina Antonipillai
Department of Global Health
McMaster University
Hamilton, Ontario, Canada
416-460-1451
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Thank you for accepting our invitation to be interviewed. The following information will describe the purpose of our study and the care we have taken to protect your privacy and confidentiality. With your permission we will take a few minutes before the interview, to review the information and answer any questions or concerns you have with regards to the interview and the research study.

Purpose of the Study:

The study is called, “The impacts of the Interim Federal Health Program (IFHP) reforms on healthcare access and provision in Canada: A Stakeholder Analysis”. It will be conducted by Valentina Antonipillai, Global Health Master’s student at McMaster University under the supervision of Dr. Andrea Baumann, as part of her Master’s thesis requirements.

This study aims to obtain the perceptions of key stakeholders on the current situation of accessing and providing healthcare for refugee claimants through the Interim Federal Health Program after a series of program changes during the past five years. Its main objective is to document and analyze refugee policy reform stakeholder perspectives to subsequently guide decision-makers, prior to the implementation of a permanent IFHP, through a consensus-building process.

Procedures:

As a key informant, participating in this study entails you to share your perspective on the IFHP changes over the past 5 years to the research team, particularly the 2014 IFHP reforms regarding

refugee claimant access to healthcare and health professional provision of care within the system. The interview will last approximately 30 to 60 minutes.

Your participation in this interview is entirely voluntary and confidential. You are able to refuse to answer any question at any time and/or withdraw from the interview at any time. This interview will be recorded and transcribed at a later date. It will be kept strictly confidential and under no circumstances will your name or identifying characteristics be included in this report.

Potential Harms, Risks or Discomforts:

We know of no direct harms or risks associated with taking part in this study. Remember that you can skip any question you like or stop the interview at any time. Every effort will be made to protect your privacy when participating in the interview. To protect your identity, a personal identification number will be used in all of our transcriptions. Project materials and published study results cannot and will not reveal your identity or that of your organization or institution. Any inconvenience or discomfort may include the time commitment associated with taking part in this interview.

Potential Benefits:

You will not benefit directly from participating in this study. However, your experience and perspective will contribute to advancing knowledge in the refugee health policy arena, regarding refugee claimant access to healthcare and health professional provision of care. The community may benefit from this study as the findings will illustrate stakeholder perspectives in the refugee claimant health policy area providing knowledge on the benefits and disadvantages of current health policy reforms.

Confidentiality:

We will make every effort to keep your information confidential, and your personal information will be blurred or obscured so that it will be difficult to identify you in our project materials or published study results. Directly identifying information such as your name will not be included in the final report. Your interview script and transcript will be coded with a personal identification number and kept in a locked filing cabinet separate from your consent form. The data collected from this study will be stored on our secure server at McMaster University. All of the data will be secure, password protected and locked. Only the research team will have access to the information and all of the team members are committed to protecting your privacy and confidentiality. Your decision to participate or not will not affect your access to health or community services in any way, and will be known only to your interviewer.

Participation and Withdrawal:

Your participation in this interview and study is voluntary and confidential. You are welcome to stop the interview at any time and for any reason, even after signing the consent form.

You may refuse to participate in this project. You may also withdraw from this study at any time and for any reason, however once data is collected, it cannot be removed by the researcher. You may withdraw from the study at any time by contacting Valentina Antonipillai or Dr. Andrea Baumann and at your request your information will be destroyed.

If you do agree to continue, you may also choose to stop the interview at any time and for any reason. If you do not want to answer a particular question, just let me know and we will skip it. If you would like to ask me questions, please feel free to do so at any point. All original interview scripts and audiotapes will be destroyed at the completion of the study following Personal Health Information Protection Act (PHIPA) regulations.

Study Debriefing:

Should you wish a summary of our findings we would be happy to mail them to you after the completion of the study. The interviewer will ask for your contact information so we may follow through on your request.

Questions:

If you have any questions about this study, please call Valentina Antonipillai at 416-460-1451 or Dr. Andrea Baumann at McMaster University at 905-525-9140 ext. 22205.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HIREB at 905.521.2100 x 42013.

CONSENT

By signing this form, I agree that:

1. I understand the purpose of the study, “The impacts of the Interim Federal Health Program (IFHP) reforms on healthcare access and provision in Canada: A Stakeholder Analysis,” conducted by Valentina Antonipillai and Dr. Andrea Baumann of McMaster University.
2. I understand my rights and the provisions in place to protect my privacy and confidentiality.
3. I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
4. I agree that the interview can be recorded.
5. I understand that I may withdraw from the study at any time, if I choose to do so, and that doing so will not affect my use of services.
6. I agree to take part in this study by participating in a research interview and I have been given a signed copy of this form.

I would like to receive a summary of the study’s results. Yes No

If yes, where would you like the results sent:

Email: _____

Mailing address: _____

Written Consent

Name of Participant (Printed)	Signature	Date
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Consent form explained in person by:

Name of Interviewer (Printed)	Signature	Date
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Oral Consent

Interviewee gave oral consent (recorded):

Name of Interviewer (Printed)	Signature	Date
-------------------------------	-----------	------

If you have any questions about this study, please call Valentina Antonipillai at 416-460-1451 or Dr. Andrea Baumann at McMaster University at 905-525-9140 ext. 22205.

If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905.521.2100 x 42013.

Appendix D: General Stakeholder Interview Guide

Key Informant Interview Guide

Introduction:

I am a M.Sc. student in the Global Health program at McMaster University. I am conducting a study of the Interim Federal Health program impacts on refugee claimant healthcare access and provision in Canada by exploring the perspectives of stakeholders who have an interest in or are affected by the IFHP reforms. The intent of this interview is to seek your opinions and perspectives regarding the recent reforms of refugee health policy.

General questions:

1. What is your involvement with the refugee claimant community and your role as _____?
2. How long have you worked at _____ / resided in Canada as a refugee claimant?
3. In what other way are you involved with the refugee claimant community?

Interim Federal Health Program:

4. What is your understanding of the Interim Federal Health Program (IFHP)?
5. What is your perspective of the recent changes to the IFHP?

Stakeholder Analysis:

6. What is your perspective on the benefits to you (and your organization) regarding the IFHP recent reforms as implemented by the Canadian government?
7. What is your perspective on the disadvantages to you (and your organization) of the IFHP recent reforms?
8. Which aspects of the recent IFHP reforms do you support?
9. For those aspects of the recent IFHP reforms that you support,
 - a. In what manner would you practically demonstrate this support?
 - b. Would you take the initiative in supporting the recent reforms, or would you wait for others to do so?
 - c. Do you have financial or human resources available to support this policy?
 - d. Which resources are available and how quickly can they be mobilized?
 - e. Would this support be public?
 - f. What conditions would have to exist for you to express this support?
 - g. Would you partner with any other persons or organizations in these actions? Which ones?
10. Which aspects of the recent IFHP reforms do you oppose?
11. For those aspects of the recent IFHP reforms that you oppose,
 - a. In what manner would you practically demonstrate this opposition?
 - b. Would you take the initiative in opposing the recent reforms, or would you wait for others to do so?

- c. Do you have financial or human resources available to oppose this policy?
- d. Which resources are available and how quickly can they be mobilized?
- e. Would this opposition be public?
- f. What conditions would have to exist for you to express this opposition?
- g. Would you collaborate with any other persons or organizations in these actions?
Which ones?

Accessing Healthcare

- 12. Do you think the recent IFHP changes had an impact on access to health services for the refugee claimant population?
 - a. Is their current access to healthcare similar to before 2014? Before 2012?
- 13. What are aspects that contribute to blocking or promoting access to healthcare services for this population?
- 14. What are the policies and practices in your institution/ the place you seek care that might influence refugee claimant access to health services?
- 15. What conditions or tools are necessary to improve access to healthcare for refugee claimants?

Provision of Healthcare

- 16. Do you think the recent IFHP changes had an impact on provision of health services for the refugee claimant population?
 - a. Is the current provision of healthcare similar to before 2014? Before 2012?
- 17. What are aspects that contribute to blocking or promoting provision of healthcare services for this population?
- 18. What are the policies and practices in your institution/ the place you seek care that might influence provision of health services by healthcare or refugee claimant care providers?
- 19. What conditions or tools are necessary to improve provision of healthcare for healthcare providers?

Final Comments:

- 20. Do you have any additional comments you would like to add?
- 21. Is there anyone/stakeholder you would recommend that I interview for purposes of this study?

Appendix E: Refugee and refugee claimant stakeholder interview guide

Key Informant Interview Guide

Introduction:

I am a M.Sc. student in the Global Health program at McMaster University. I am conducting a study of the Interim Federal Health program impacts on refugee claimant healthcare access and provision in Canada by exploring the perspectives of stakeholders who have an interest in or are affected by the IFHP reforms. The intent of this interview is to seek your opinions and perspectives regarding the recent reforms of refugee health policy.

General questions:

1. What is your current status and how long have you had this status?
2. How long have you resided in Canada as a refugee claimant?

Interim Federal Health Program:

3. What is your understanding of the Interim Federal Health Program (IFHP)?
4. What is your perspective of the recent changes to the IFHP?
5. What is your perspective on the benefits regarding the recent IFHP reforms?
6. What is your perspective on the disadvantages of the recent IFHP reforms?

Stakeholder Analysis:

7. Which aspects of the recent IFHP reforms do you support? Why?
8. Which aspects of the recent IFHP reforms do you oppose? Why?

Accessing Healthcare

9. Do you think the recent IFHP changes had an impact on access to health services for the refugee claimant population? How so?
 - a. Is your current access to healthcare similar to before 2014? Before 2012?
10. What are aspects that contribute to blocking or promoting access to healthcare services for this population?
11. What are the policies and practices in the place you seek care that might influence refugee claimant access to health services?
12. What conditions or tools are necessary to improve access to healthcare for refugee claimants?

Final Comments:

13. Do you have any additional comments you would like to add?

Appendix F: Recruitment Email Script

EMAIL SCRIPT - INVITATION TO POTENTIAL KEY INFORMANTS

Subject line: Interim Federal Health Program stakeholder analysis - invitation to participate in research.

Message

We invite you to take part in a research study that is collecting individual/ organizational perspectives about the changes to the Interim Federal Health program during the past five years. This is part of a study on, "The impacts of the Interim Federal Health Program (IFHP) reforms on healthcare access and provision in Canada: A Stakeholder Analysis". We are analysing stakeholder perspectives on the current situation of accessing and providing healthcare for refugee claimants through the Interim Federal Health Program to guide decision-makers, prior to the implementation of a permanent IFHP, through a consensus-building process, in which a program reflecting stakeholder interests can be implemented. It is conducted by Valentina Antonipillai, Global Health Master's student at McMaster University under the supervision of Dr. Andrea Baumann, as part of her Master's thesis requirements. This study has received Hamilton Integrated Research Ethics Board approval.

If you would like to take part in this study and share your point of view, please contact the principal investigator, Valentina Antonipillai at antoniv@mcmaster.ca or 416 460 1451; or Dr. Andrea Baumann at baumanna@mcmaster.ca or 905-525-9140, extension 26631.

Participation in the project is voluntary and confidential. The in-person or telephone interview will approximately last 30 to 60 minutes, and will be audio-recorded. Your name and/or organization will not be identified with the information you provide. Identifying information will be blurred so that it will be difficult to identify you in the final report. We hope you will contribute your valuable opinions to this study as an important stakeholder interested in or impacted by the IFHP reforms.

Thank you very much for your help! Your collaboration is essential to generate and overview of stakeholder interests and positions through which you all may influence the refugee health policy-making process. Your contribution to this research is most valuable and deeply appreciated!

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