Creating Complex Systems: The Implications of the Immigration System Reforms for Refugee Health (2012)

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Abstract

In June 2012, the Canadian federal government introduced a new legislature, which drastically reformed the Canadian immigration system. During this time the Conservative government reformed the Interim Federal Health Program (IFHP), completely transforming health coverage for asylum seekers. This overhaul created a hierarchy, whereby asylum seekers would qualify for different levels of coverage based on their claimant status. This study explores the impacts of this policy change and outlines the inequity consequential to the reforms of 2012. It includes secondary thematic data analysis of interviews conducted with medical health professionals regarding the impacts of the 2012 decision. The study provides a comprehensive look at the implications of patchwork policies through three prominent themes: *potential risks to women's health; barriers to healthcare access (language, fear, cost); significant medical bills and delays lead to additional health problems.* Finally, I conclude with policy recommendations for future federal and provincial governments.

List of Abbreviations

DCO Designated Country of Origin (deemed to protect rights of citizens)

Non-DCO Non-Designated Country of Origin (deemed to potentially not protect rights of citizens)

DFN Designated Foreign National

UNHCR United Nations High Commissioner for Refugees

IRPA Immigration and Refugee Protection Act (Canada)

BRRA Balanced Refugee Reform Act

UN United Nations

UDHR Universal Declaration of Human Rights

PSR- Privately Sponsored Refugee

GSR- Government Sponsored Refugee

IFHP- Interim Federal Health Program

Introduction

Bill C-31 is a recognized piece of legislation that was introduced in April 2000 (Bossin, 2001), and fully implemented in June 2012 (Diop 2014). *Bill C-31* is formally known as the *Act to Amend the Immigration and Refugee Protection Act, the Balanced Refugee Reform Act, the Marine Transportation Security Act and the Department of Citizenship and Immigration. Bill C-31* succeeded the reforms of the *Balancing Refugee Reform Act (BRRA*). The purpose of the *BRRA* was to clear backlogged refugee claims, expedite wait times and reduce unfounded refugee claims. The *BRRA* and the provisions of *Bill C-4*, the Preventing Human Smugglers from Abusing Canada's System Act, were incorporated in the construction of Bill C-31 (Cleveland & Rousseau, 2012; Dawson, 2014). The proposed purpose of *Bill C-31* was to deter abuse of the Canadian immigration system by introducing new offences for trafficking; increasing penalties for unfounded claims and offences; increasing the government's power of detention, and increasing overseas officers in order to reduce irregular arrivals (Dench, 2001).

To date, *Bill C-31* has done little to protect the Canadian immigration system against system abusers, human traffickers and human smugglers (Atak, Hudson, & Nakache, 2017; 2018). In fact, it has worked to create a complex system that has impacted and continues to impact, thousands of asylum seekers on a daily basis (Baines, 2017). Despite the Canadian government's international obligation and agreement with the Declaration of Human Rights, Canada has failed to provide a safe environment for displaced peoples (Dawson, 2014; Diop, 2014; Harris & Zuberi, 2015). With the introduction of Bill C-31, the federal government created a ripple effect of inequity and inequality that manifested in creating barriers to healthcare access, employment access, and housing for refugee claimants (Harris & Zuberi, 2015). The most prominent barrier to the wellbeing and health of refugee claimants was the reform of 2012 and changes made to the Interim Federal Health Program (*IFHP*) (Harris & Zuberi, 2015; Barnes, 2013).

Objectives and Key Questions

The Interim Federal Health Program *(IFHP)* is a temporary health insurance program that is offered by the Canadian federal government to refugees, refugee claimants and protected people (Olsen, El-Bialy, Mckelvie, Rauman & Brunger, 2016). Prior to the reforms of 2012, *IFHP* was available to all refugees and protected peoples in Canada with similar benefits, regardless of their refugee category. On June 30th, 2012, the Conservative federal government, under the leadership of Stephen Harper, implemented changes to IFHP (Atak et al., 2017). The changes to the program still offered healthcare coverage to various categories of claimants and refugees but eliminated coverage for certain types of claimants (Olsen et al, 2016).

In relation to the changes made to the IFHP in 2012, I conducted a secondary data analysis on interviews with service providers to understand the consequences and implications the immigration system reforms of 2012 had on refugee claimants when accessing healthcare. Through the principles of human rights, I ask the overarching question *"What were impacts of the reforms of 2012, specifically the changes made to the IFHP and how did they affect refugee populations trying to access healthcare services in Canada"?* I hypothesize that both service providers and claimants experienced several barriers when trying to access and provide services due to the complications created by IFHP and the federal government's patchwork of policies. In line with content literature, I expected to find severe adverse effects and consequences on the health of refugee populations post-reforms. In addition to a secondary data analysis, I incorporate findings from a scoping review that helped inform my understanding of *Bill C-31*. The findings from the scoping review act as a basis for this MRP. I used human rights and intersectionality frameworks for my analysis to explain the inequities created by this policy. For this research, I draw on several bodies of literature to guide my analysis. The Universal Declaration of Human Rights will be the guiding document used to understand the impacts of *Bill C-31* and *IFHP* as a glaring human rights issue stemming from purposeful government neglect. The academic works of Kimberle Crenshaw on intersectionality (1990) will also guide my understanding of the findings of the scoping review and its effects on refugee claimants who are accessing healthcare.

This research contributes to a larger body of work on refugee claimants and inequitable policies in Canada. This study adds to the discussion by illuminating the impacts that patchwork policies have on vulnerable bodies within Canada and the severe repercussions that occur when policy protecting vulnerable people are altered for economic and resource management. The study's aim is to provide a thematic analysis of key issues surrounding these pieces of legislation. The study concludes by noting ways to improve access to healthcare and recommending long-term policy improvements for refugees.

This major research paper is divided into the following sections: Section 1 Background Literature, Content Literature, and Scope; Section 2: Preliminary Analysis, Method, and Methodology; Section 3 Findings; Section 4: Discussion, Conclusion, and Recommendations; Section 5: Appendices.

Section 1: Literature Review

A. Background Literature

According to the United Nations High Commissioner for Refugees, a refugee is defined as a person residing outside a country of their nationality. This person is unable to return due to fear of political, racial, religious, and membership persecution (UNHCR, 1951). Asylum seekers are defined as people who migrate internationally in search of protection, however until determination they cannot be considered refugees (The UN Refugee Agency, 2018). A refugee claimant is defined as a person who has made a claim for refugee status and protection from an asylum country (The UN Refugee Agency, 2018).

Globally, the number of refugees continues to increase and is projected to rise at an exponential rate in the coming years (Canadian Council for Refugees, 2018; United Nations High Commissioner for Refugees UNHCR Global Trends, 2018). Currently, there are 68.5 million forcibly displaced people worldwide (The UN Refugee Agency Figures at a Glance, 2019). Of those individuals, 25.4 million are refugees, 3.1 million are asylum seekers and 40 million are internally displaced peoples (The UN Refugee Agency, 2019). Currently, a total of 57% of those refugees migrated from 3 countries: South Sudan (2.4 million), Afghanistan (2.6 million) and Syria (6.3million) (The UN Refugee Agency, 2018).

Across the globe, Canada is often perceived as a safe haven for migrants and asylum seekers (Aery & Cheff, 2018; Andrews, 2018; Simmons, 2010) and is praised from national and international bodies as a country that resettles thousands of refugee claimants annually (Olsen et al, 2016; Taylor, 2018). Resettlement is defined as the act of transferring refugees from an asylum country to another, permanent residence (UNHCR, n.d.). In Canada, resettled refugees arrive as permanent residences. These refugees are accepted overseas and are resettled upon their arrival. They are offered *resettlement assistance (RAP),* which provides them with income support and immediate essential services or with the equivalent level of financial and settlement support from private sponsors. Refugee claimants arrive in Canada and request to have their cases heard and approved by the Immigration Review Board (*IRB*). Refugee claimants do not qualify to receive RAP and are not considered resettled (Government of Canada, Terms, and definitions related to refugee protection, 2018).

Canada's refugee program does not provide equitable access to services for many types of refugees who seek asylum (Atak, Hudson & Nakache, 2018). While the inequitable practices of Canadian policies can be traced back several decades, punitive practices were particularly introduced during the Harper government, more specifically during the "2012 IFHP reforms" (Harris & Zuberi, 2015; Olsen et al, 2016).

During the reform of 2012, legislation was passed that restricted access to many basic human rights in the form of increasing refugee detention, accelerating refugee hearings and withdrawing the right to appeal refugee board decisions for claimants originating from particular countries (Atak et al., 2017). The purpose of the reform of 2012 and *Bill C-31* as propagated by the Canadian government was to "deter abuse" of the Canadian immigration system (Olsen et al, 2016). However, similar to most political propaganda, the counter-narrative presents a different story. Indeed, during the reforms of 2012, a reduction in the number of inland refugees accepted for resettlement by the Canadian government was identified (Atak et al., 2017); however, a reduction of inland refugee intake numbers does not necessarily equate to the protection of the immigration system. Utilizing the language of national security and resource management the Canadian federal government justified harsh methods of refugee treatment (Atak et al., 2018). While Canada's dominant reputation of accepting refugee claimants and immigration remains strong, the counter-narrative that tells a different story of unintended

consequences and clear violations of human rights (Atak et al., 2017; Atak et al., 2018; Dawson 2014; Harris & Zuberi, 2015).

i. Global Perspectives on Refugees

International migration and mobility have thrived through the process of international globalization that occurred during the early 20th century (Solimano, 2018). This coupled with lower transportation costs, job opportunities and prospects of political and economic stability have made migration more desirable than ever (Solimano, 2018). From 1990-2015, international migration has increased at an exponential rate. The Global North saw an increase of 58.1 million migrants from 1900-2015, while countries in the Global South grew at a faster pace between the years of 2000-2010 with a growth of 16 percent and a total of 33 million from 1990-2015 (Solimano, 2018). As migration continues to flourish, forced migration, whereby a migrant is forced to leave their home country and seek asylum in a host country, has also increased (UNHCR, n.d.).

Globally, the three main countries that produce the highest number of refugees are Syria (5.5 million), Afghanistan (2.5 million) and South Sudan (1.4 million) (UNHCR, 2019). These three countries have been affected by war, political unrest and armed conflict resulting in forcibly displaced populations (Solimano, 2018).

Historically, political institutions, climate change, and natural disasters are the root causes of current and previous refugee crises (Baines, 2017; Hein, 1993; Islam, 2018; McAdam, 2016). It is the global political powers of the state, which shift social and economic conditions, creating unbearable circumstances in countries of origin (Hein, 1993; Jacobsen, 2002; Lacroix, 2004). Moreover, both human enacted and natural climate change also create circumstances of necessary migration. These circumstances, if not created by policy, are continuously exacerbated by political powers, causing integration and resettlement of refugees to become increasingly difficult (Hein, 1993; Islam, 2018; Jacobsen, 2002; Lacroix, 2004).

Similar to immigrants, refugees experience a mixture of political and economic challenges when migrating to asylum countries (Hein, 1993; Lacroix, 2004). The majority of discourse surrounding global migration patterns is fiscal (Allen et al., 2018). Drawing on knowledge that most refugees seek asylum in low-income countries (United Nations High Commissioner for Refugees UNHCR Global Trends, 2018)

industrialized nations fear the cost of claimants looking to resettle due to the social and fiscal costs of intake and resettlement (Achiume, 2015; Li, & Halli, 2003; Ruist, 2015). This concern is often exaggerated and does not serve to benefit either the state or refugee claimants since it creates a cycle of inequitable practices and violations of human rights (Harris & Zuberi, 2015). By continuing the dominant narratives of fiscal and social costs of resettlement, the state can feel pressured by external bodies or the public to reduce social services to refugee claimants, as in the example of the IFHP. The cuts to essential services can then create a cycle of further reductions to more services that essentially lead to violations of human rights (Achiume, 2015; Harris & Zuberi, 2015).

In fact, a study conducted by the Canadian Healthcare Association (2012) concluded that the average cost for a refugee claimant's healthcare was only $660 annually, while the cost for the average Canadian in healthcare and social services was $6,4141 per capita (Harris & Zuberi, 2015). A recent study conducted in Sweden suggests that there is a gross over-estimation in the cost of social spending and the intake of refugees (Ruist, 2015). A study conducted in Canada during the IFHP overhaul indicated that the social spending on refugees with accepted claims is equivalent to if not lower than social spending on other low-income Canadians (Harris & Zuberi, 2015).

ii. Current Canadian Immigrant Intake

Canada has two distinct refugee programs: The Refugee and Humanitarian Resettlement Program and the In-Canada Asylum Program (Immigration and Refugee Board of Canada, 2018). The Refugee and Humanitarian Resettlement Program is for any asylum seeker outside of Canada who requires protection. Resettled refugees can be privately sponsored (PSRs) or government-assisted refugee (GARs). A GAR has been selected by the government (often on the recommendation of UNHCR) for permanent residency and resettlement in Canada. GARs are entitled to social services in the form of housing, healthcare and income for the first year (Immigration and Refugee Board of Canada, 2018). A privately sponsored refugee is a person that has been selected and funded to resettle in Canada through a non-governmental body (Immigration and Refugee Board of Canada, 2018). Private sponsors can be sponsor agreement holders that are organizations, which have

agreements with the government to sponsor refugees when they arrive in Canada from abroad (Immigration and Refugee Board of Canada, 2018). They can also be groups of at least five Canadian citizens (Groups of Five) or community organizations.

Refugees can also be sponsored through The Blended Visa Office-Referred (BVOR). This form of sponsorship works with the UNHCR to match refugees with private sponsors in Canada. Refugees accepted in the program are offered 6 months of government assisted support, 6 months of private sponsorship financial, emotional and social support and supplemental healthcare coverage (IFHP). This IFHP is available for GARs and PSRs, in addition to their provincial coverage, to cover supplemental health care costs and any lag between arrival and receipt of their provincial coverage due to their permanent status (Immigration and Refugee Board of Canada, 2018).

The *In Canada Asylum Program* differs by providing refugee protection to people who apply for refugee status after arriving in Canada. This form of asylum is offered to individuals who have a fear of persecution, or at risk of torture or punishment in their own country (Immigration and Refugee Board of Canada, 2018). These individuals are not given the financial and settlement support that is offered to resettled refugees.

During the intake of 2017, Canada welcomed 300,000 new permanent residents (Canadian Council for Refugees, 2019). The overall immigration numbers in 2017 were historic when compared to earlier years; for instance, during the period of 1996-2000 Canada only landed 200,000 new immigrants (Canadian Council for Refugees, 2019). Of those 300,000 new immigrants (2017), 40,000 were protected people or claimants of asylum (refugee claimants), 172,500 of those individuals were economic immigrants (federal economic workers, approved and supported by the federal government), 84,000 were family immigrants (spouses, parents, children, grandparents or siblings of existing Canadian citizens) and 7,500 were government-assisted refugees (GARs) (Canadian Council for Refugees, 2019). In line with Canada's global reputation, these numbers appear to be significant and speak volumes about the federal government's international commitment to value human rights (Hari, 2014; Levine-Rasky, Beaudoin & St Clair, 2014). However, with closer evaluation, the numbers tell a different story. When further analyzed the categories and the number of GARs that were offered

permanent residency in 2017 was only 47,000 (Canadian Council for Refugees, 2019). As the global refugee crisis continues to worsen, 47,000 refugees being offered permanent residency is insufficient.

While Canada works to bolster its economic growth through migrant labour, it still maintains the dominant narrative of migrant acceptance and resettlement (Guo, 2018). Although Canada does welcome hundreds of thousands of “new residents” annually, the term “new residents” does not directly translate to resettled refugees (Canadian Council for Refugees, 2019). The majority of migrants accepted are economic migrants. Carefully termed, "new resident" portrays Canada's global reputation in a positive light. During the same period of time, Canada accepted over 200,000 temporary migrants, many of who want permanent residency but were denied due to the potentials gains from economic immigrants (Levine-Rasky et al., 2014; Liempt & Sersli, 2013). The significant inequity in refugee resettlement demonstrates the Canadian government’s strong preference for economic migrants over refugees. This provides some context to the intention behind *Bill C-31* and the service rollbacks that were put through in the reform of 2012. Canada’s continued failure to accept and resettle higher numbers of refugees illustrates its strong desire to maintain its own economic wellbeing while disregarding its international responsibilities to human rights (Brotman & Lee, 2011).

If we consider the growing refugee crisis and the predicted spike in refugee numbers across the globe, we would assume that Canada would be preparing itself for a greater resettlement strategy in 2019. Although the federal government has decided to increase its overall immigration resettlement in future years, it has failed to increase planned refugee resettlement in 2019 (Canadian Council for Refugees, 2018). In fact, the federal government is now using a targeted approach to refugee resettlement (Canadian Council for Refugees, 2018). Instead of resettling refugees from many regions across the globe, Canada is targeting specific countries and placing restrictions of the number of refugees being accepted or privately sponsored from regions such as Africa (Canadian Council for Refugees, 2018). Private sponsorship is still being encouraged, however, more emphasis is being placed on countries the federal government has identified as high priority (Canadian Council for Refugees, 2018). Although the slight increase from 7500 (GARs) (2018) to 9300 (2019) is welcomed, a greater

need of acceptance of refugee claimants is required and should be adjusted based on the expected increase of displaced people across the globe (Canadian Council for Refugees, 2019).

iii. Canadian Immigrant Intake (2012)

During the reforms of 2012, the Canadian immigration and refugee system underwent a significant transformation (Atak et al., 2018; Bates, Bond & Wiseman, 2015; Olsen et al., 2016). The transformation resulted in new pieces of legislation being introduced that were specifically geared towards national security, the removal of backlogs, the removal of bogus refugees, and the improvement in the efficiency of the immigration system (Bates et al., 2015). This highly publicized reform worked to undermine the integrity of refugees and vulnerable peoples who were seeking basic human rights (Atak et al., 2017; Bates et al., 2015). During the reforms of 2012, Canada welcomed 257,905 new immigrants. Of those immigrants, 160,829 were economic immigrants, 65,018 were family reunification and 31,987 were refugees (Immigration, Refugees and Citizenship Canada, 2015). Interestingly, after the reforms of 2012 and in later years, the number of refugees decreased from 31,987 in 2012 to 29,812 in 2014 (Immigration, Refugees and Citizenship Canada, 2015).

In addition to the decrease in refugee intake, punitive treatment of claimants was permitted, which introduced new committees such as the Refugee Appeal Division (RAD) and Pre-removal Risk Assessments (PRRA). The RAD is a division implemented by the federal government that appeals against decisions of the Refugee Protection Division (RPD) to allow or reject claims for refugee protection (Immigration and Refugee Board of Canada, 2018). A PRRA is an assessment that is conducted once a refugee is being deported from Canada. In line with Canada's international obligations, no refugee can be deported to a country that is deemed unsafe or if they may be at risk of persecution (Immigration and Refugee Board of Canada, 2018). Previous to 2012, claimants who had rejected claims were given the opportunity to apply for a PRRA. Those claimants were allotted 15 days to submit an application and 30 days to submit a new application if the first application was denied (Atak et al., 2018). After 2012, claimants were no longer given that period of time. Rejected applicants are now required to wait a full year before submitted a new appeal (Atak et al., 2018). Moreover, after 2012, the

RAD accelerated timelines, increased mandatory detention of minors (16-17-year-olds), and delayed secondary appeal claims (Atak et al., 2018). Punitive practices were deemed acceptable by the federal government and allowed for expedited deportation and removal of residents upon loss of status. Timelines surrounding status and appeal were tightened, and terms of criminality relating to refugees were expanded, in efforts to clear "backlog" and keep Canada "safe" (Atak et al., 2017; Bates et al., 2015).

iv. Refugees and the Canadian Comparison

In 2017 the UNHCR ranked countries providing needed asylum to refugee claimants per capita, (United Nations High Commissioner for Refugees UNHCR Global Trends, 2018). Germany ranked 8th (970,320), France ranked 17th (337,143), United States ranked 20th (287,065), and Canada ranked 34th (104,748) (United Nations High Commissioner for Refugees UNHCR Global Trends, 2018). Consequently, Turkey (3.4m), Uganda (1.4m), Pakistan (1.4m), Lebanon (1m), and Iran (979,435) are among the top refugee-hosting countries in the world that provide temporary asylum (United Nations High Commissioner for Refugees UNHCR Global Trends, 2018). Although it appears as though Canada resettles refugees at a lower capacity, the per capita number of refugees given permanent residency is higher than the USA and Europe based on Canada's population and geography (Bates et al., 2015). Canada also has less inland migration than countries in Europe and the Middle East, while countries in Europe offer residency to more claimants through that inland route (Zaiotti, 2016).

A cross-comparative study between Sweden and Canada assessed the employment and earnings of refugees and family reunion immigrants. The study found that when external variables were controlled, the employment rates for Canada and Sweden were approximately the same (Bevelander & Pendakur, 2014). It appeared that refugees in Canada do better than family reunification immigrants in Canada. Refugees in Canada were more likely to find employment and earn a higher wage than refugees in Sweden. Comparatively, Sweden had lower intake numbers (per capita) across the board with both refugee and family reunion immigrants (Bevelander & Pendakur, 2014). However, Sweden provided all migrants with an 18-month resettlement program, complete with language and labor market schooling, whereas Canada did not. Canada only provided

language training, housing assistance and resettlement assistance to government-assisted refugees and normally only for 12 months. Privately sponsored refugees received the same benefits but were funded and received resettlement support through their sponsor. Family reunion migrants were only allotted language training, and their economic cost was the responsibility of their host family. The study concluded by proposing that the assistance provided by the Swedish government has very positive effects on resettlement. Conclusions can be made that both Canada and Sweden have positives and negatives in their comparative refugee resettlement programs (Bevelander & Pendakur, 2014).

In line with service access, a study conducted by Nakahie (2017) evaluated the specific service needs of immigrants and refugees living in Ontario. Results of the study found that both refugees and immigrants placed major service priority on government services and language skills; information about Canadian life and access to community services; education and work in Canada; social and professional networks and community involvement (Nakahie, 2017). Interestingly, health services were not identified as a major priority. The study identified that clients with higher education required fewer services than their counterparts (Nakahie, 2017). It concludes by suggesting that services are a crucial factor in the success of new immigrants and refugees in Canada (Nakahie, 2017).

The results of both studies speak volumes regarding the services provided to refugees and claimants in Canada. Although neither study placed particular emphasis on healthcare as a critical service, both studies did highlight the importance of specific services and service access for new migrants and refugees. While the studies do not address the reforms of 2012 and the reduction of health services during that period, we can infer that a reduction of services of any kind does have negative repercussions for the population and does have unintended negative consequences for the public.

Though comparisons about healthcare services can be drawn from this study, McKeary and Newbold (2010) discuss the specific repercussions of barriers to healthcare access for refugees in Canada. The authors of the study suggest that the healthcare experience is not a "one size fits all" system. They indicate that the refugee experience is unique and cannot be lumped into the immigrant experience. The study illustrates the systematic impacts of barriers to accessing the healthcare system such as language, cultural competency, healthcare

coverage, isolation, poverty, and transportation (McKeary & Newbold, 2010). In line with the discourse of this paper, healthcare coverage was outlined as one of the most prominent barriers. The authors outline that insurance is a very complex barrier as it contributes to additional issues in the form of cost, paperwork, and stress (McKeary & Newbold, 2010).

v. Refugee Experience

When entering a host country under asylum and protection, refugees experience vetting and stigmatization of their current circumstance (Ardalan, 2017). The vetting procedures and policies are an experience that is unique from those of other new Canadians. Vetting is the process of performing an in-depth, rigorous background check (Ardalan, 2017). This can often be prejudicial, discriminatory and culturally inappropriate to an already vulnerable population (Ardalan, 2017; Carlier, 2016). Although new immigrants experience their own type of vetting, it is less severe and they often have the social and economic support from their family, friends and the government (Burgoon, 2014). Both the experiences of vetting and stigmatization of refugee circumstances can cause detrimental psychological effects (Keyes, 2000).

If a refugee is a person of non-white passing origin, exhibits any religious indicators, or has a different sexual identity, they can experience intersectional oppression when entering a host country (Vervliet, De Mol, Broekaert & Derluyn, 2013). They may even be a target of extreme vetting since they may be stereotyped as a security threat (Ardalan, 2017). This coupled with pre-migration experiences, and both the physical (e.g. abuse, violence, rape, etc.) and mental toll (e.g. PTSD, depression, anxiety) of being a refugee clearly underlines the difference between immigrants and refugees, further emphasizing the vulnerability of being a refugee (Keyes, 2000). In line with the refugee experience, refugees also demonstrate clear resourcefulness. They are agents of survival who have made the decision to migrate as a result of unstable societal conditions, political persecution and often climate change (Sleijpen, Boeije, Kleber, & Mooren, 2016).

vi. Refugees as the “Other”

Social constructs that drive dominant narratives in society often portray refugees as the “other” (Inokuchi & Nozaki, 2005; Said, 1979,1985). It is the institutions of knowledge and power that have shaped an

idea of us versus them (Abu El-Haj, 2005; Hitchcock, 1993; Said & Barsamian, 2003). This politically driven construct emphasizes the notion that words such as migrant, asylum seeker, and refugee mean that individuals given that title are different from others in society, are alien and do not belong (Brown, 2018; Hugman, Pittaway & Bartolomei, 2011; Lowry, 2002). Researchers have published works of literature surrounding the notion of being a refugee, the idea of "Refugeeness." (Lacroix, 2004) as being uniquely universal to an individual who has experienced being a refugee. Although each refugee experience varies in relation to the individual or circumstance, the occurrence of being forcibly uprooted and displaced from a country is unique to refugees (Lacroix, 2004; Bates et al., 2015).

The construct of "Refugeeness" emphasizes that the experience of being displaced and forced out of one's homeland creates a specific type of circumstance that alters an individual's life perpetually. Moreover, the construct suggests that the concept of "Refugeeness" can only be understood and explained by individuals who have experience being a refugee, that there is no similar experience to being displaced (Achiume, 2015; Lacroix, 2004).

Research on refugees and asylum seekers often highlights how the experience of being a refugee is distinctly different and life-altering, emphasizing the distinction between refugees and the rest of the world. The dominant narrative and those who thrive off power and privilege in society often cling to this idea. Positioning refugees as foreign bodies who are "unwanted" and have entered Canada "illegally" without invitation generates fear in Canadians (Brown, 2018; Said, 1985). This idea is a representation of a bad asylum seeker or bogus refugee (Levine-Rasky et al., 2014; Said, 1985). With this fear, the dominant narrative rapidly spreads and policy rollbacks such as the reforms of 2012 are easily implemented. Utilizing the language of security and justified terminology such as "deter abuse" and "national security" maintains fear within the population. This further allows the state to make decisions that are counter to fundamental human rights (Atak et al., 2018; Bate et al., 2015; Lee & Brotman, 2011).

B. Content Literature

i. Canada and Bill C-31

In 2012, the Canadian federal government introduced *Bill C-31*. Formally known as the *Protecting Canada's Immigration System Act, 2012* (Cleveland & Rousseau, 2012), *Bill C-31* introduced new categories for refugee claimants (Appendix A): Non-designated Countries of Origin (Non-DCO), Designated Countries of Origin (DCO) and Rejected Refugees. With the implementation of *Bill C-31*, DCO claimants were no longer considered high priority refugees since the federal government determined that DCO countries were "safe" and claimants of the listed countries were deemed "capable" (Olsen et al., 2016).

DCO claimants are non-government assisted and are deemed independent of the state, meaning they are not provided with government services and assistance. *Bill C-31* gave the Canadian government full discretion to designate some refugee claimants into categories considered irregular arrivals. Irregular arrival claimants are refugee claimants entering Canada who are suspected of being smuggled through illegal travel documents (Cleveland & Rousseau, 2012). The aim of *Bill C-31* and the category distinction was to deter abuse of services being provided to refugee claimants deemed to be in the country illegally by the Canadian government, such as health, legal and social services (Liempt & Sersli, 2013; Silverman, 2014).

With the introduction of *Bill C-31* distinctions were created categorizing refugee claimants entering Canada. The categorization created a narrower image of an acceptable refugee and a hierarchical approach to migration (Harris & Zuberi, 2015; Olsen et al., 2016). The socially and policy constructed concept of an "appropriate" refugee has now become one of the dominant narratives surrounding refugee claimants throughout Canada.

In recent years media framing has become a prominent theme that stimulates the discourse in society (Wallace, 2018). Media framing is the selective portrayal of certain aspects of perceived reality that communicates a false message or fabricated narrative (Entman, 1993). In the case of the refugee crisis, media framing has worked to shift the discourse to either a humanitarian or security issue (Wallace, 2018). Wallace (2018) identified that the depiction of refugees in the media shifted pre and post-election during the transition

from the Conservative to the Liberal government. What once was a security issue transitioned to a conversation about the necessary resettlement and transition of refugees to Canadian life (Wallace, 2018). The author of the article illustrates the importance of media in political powers that influence the discourse in society, moreover highlighting the capacity that power has to re-humanize refugee discourse and shift the dominant narrative (Wallace, 2018).

As society changes, through war and political revolutions, the notion of an acceptable refugee transforms daily. A human regardless of country of origin should be given the right to claim asylum as demonstrated through the declaration of human rights (United Nations, 2015). With the implementation of DCO and Non-DCO designations, refugee claimants experience extensive barriers compromising the well-being of vulnerable, marginalized populations (Cleveland & Rousseau, 2012; Baines 2017).

ii. Bill C-31 and Bogus Refugees

While the regulatory systems of migration and border control have been extensively explored (Coutin, 2007; De Genova, 2002; Vila, 2003), the true mechanisms of border control and regulatory migration systems are beyond the scope of this paper. It should be acknowledged that border control is often linked to notions of sovereignty (Diop, 2014), whereby a state governs itself. In the case of *Bill C-31*, the increase of policing and the distinction of migrant categories (e.g. irregular arrivals) and detention of migrants is clear evidence of government intervention, whereby the government uses the language of security (Atak, et al., 2018) to remain sovereign and justify clear violations of human rights within Canada.

The true effects of *Bill-C-31* are still being uncovered as the legislation has yet to be overturned (Bates, 2015). Discourse surrounding *Bill-C31* continues to refer to refugees as different and presents a theory of “us” versus “them”. The language used bolsters the dominant narrative. For example, during the introduction of *Bill C-31*, the state used terminology such as "bogus" refugees, which projected a persistent image of fraudulence. The label of “bogus refugee” is often given to claimants who are thought to have come to Canada to take advantage of Canadian resources (Levine-Rasky, Beaudoin, & St Clair, 2014). Diop (2014) uses the example of Czech Roma claimants who the state believes are perfect examples of refugees that have come to Canada to cheat the Canadian system. Diop (2014) highlights the problematic treatment of Czech Roma refugee claimants

that were in search of permanent residency. She suggests the label of bogus refugees presents the notion that some claimants are good and deserving, while others are irregular, dangerous and threats to the system. Beyond this, the designation based on country of origin not only presents a negative image but also is considered overtly racist and discriminatory (Atak et al., 2018; Diop, 2014; Levine-Rasky, Beaudoin, & St Clair, 2014). Consumers of political propaganda and media framing (Entman, 1993), without knowledge of the state agenda and agency, regularly absorb discourse surrounding "bogus refugees". The concept of the bogus refugee further reinforces and fuels the dominant narrative throughout society, as per the agenda of the state (Atak et al., 2017).

iii. Services and the Interim Federal Health Program (IFHP)

On June 30th, 2012 under the leadership of the Conservative federal government, changes were made to the *IFHP*, outlining specific healthcare coverage provided to refugees in Canada (Olsen et al., 2016). Before the reform of 2012, the IFHP offered similar levels of coverage to all categories of refugees and claimants across all provinces and territories in Canada (Barnes, 2013). With the implementation of the new IFHP, limited temporary coverage and care were provided to protected persons, refugee claimants, rejected refugees and persons detained under the Immigrant and Refugee Protection Act (IRPA). All coverage was dependant on the status of the person. The reform completely eliminated coverage for pharmacy benefits, vision, dental and other supplementary benefits for these categories of migrants. Medication and vaccines were only provided if the disease or illness was identified as a risk to the public (Olsen et al., 2016). Moreover, coverage for all medical care except that protecting public health and safety was removed for those individuals claiming refugee status who originated from Designated Countries of Origin.

The reforms of the IFHP (2012) created a four-tiered qualification system for refugee claimants: expanded health care coverage; health care coverage; public health and public safety coverage; detainee coverage. Asylum seekers qualified for only health care coverage, or public health and public safety coverage, based on their sponsorship, country of origin or claimant status (Harris & Zuberi, 2015). Further details on coverage are provided in Appendix A, Table 2.

(1) Expanded Health Care Coverage: provides for a generous level of health and medical coverage, with an addition of supplementary benefits. This level of coverage was similar to the original coverage

that was offered to asylum seekers before the reforms of 2012. Eligible claimants include government refugees only.

(2) *Health Care Coverage*: provides basic health services for privately sponsored refugees. Claimants who have accepted refugee claims and refugees who do not appear on the DCO list are also eligible for this type of coverage. The coverage offered in tier two insures fees for doctor, nurse, hospital services, and laboratory diagnostic and ambulance service fees.

(3) *Public Health and Public Safety Coverage*: provides coverage offering the most limited amount of coverage to claimants. This coverage is only for conditions that were considered hazardous to the Canadian public. Claimants with rejected refugee claims or originating from DCO countries were eligible for tier three insurance coverage only.

(4) *Detainee Coverage:* this coverage provided care to immigration persons who have been detained. It covered medical, hospital and diagnostic care, as well as medication only when deemed necessary by a physician.

The reforms of 2012 created collective opposition from both medical and judicial professionals (Eggertson, 2013; Oscapella, 2013). The collaborative efforts from both parties contended that the changes to the IFHP were in direct violation of human rights and were breaking several international laws (Harris & Zuberi, 2015). However strong the opposition, the federal government continued to contend that the healthcare coverage provided to asylum seekers was “legitimate and lawful” (Harris & Zuberi, 2015; Kenney, 2012). The argument posits that the federal government was keeping Canadian interests safe by conserving tax dollars and the integrity of the immigration system (Harris & Zuberi, 2015).

The argument that refugee claimants were economic migrants taking advantage of the Canadian immigration systems was and is premised on false assumptions (Harris & Zuberi, 2015). The Federal government’s arguments proposed that some refugees are economically wealthy and are taking advantage of Canadian taxpayers through “free” social services (Harris & Zuberi, 2015). The revealing evidence suggests otherwise. It offers a clearer image of the experiences of being a refugee while presenting the motivation of migration as often economic with several other intersecting factors (Harris & Zuberi, 2015; Toth, 2010). In fact,

healthcare providers argue that healthcare is not a motivation for migration. Harris and Zuberi (2015) contend that refugees travel to Canada to seek asylum and to escape unfortunate circumstance. Furthermore, the framing of refugees as "bogus", exploitative, and economic migrants who have not experienced and escaped trauma, rape, displacement, and torture is truly problematic (Eggertson, 2013). It undermines the experience of being a refugee while bolstering false representations of refugee claimants in society and could discourage seeking asylum as a whole in the future (Eggertson, 2013; Harris & Zuberi, 2015).

Due to public outcry over the changes made to the IFHP, some provincial governments took a proactive step to expand the plan and provided supplementary care coverage through provincial health insurance. For example, Ontario implemented the Ontario Temporary Health Program (OTHP) in 2013 (Harris & Zuberi, 2015). The purpose of the program was to provide short-term coverage to “eligible claimants” in terms of access to essential and urgent health care as well as medication coverage to refugee claimants living in Ontario, regardless of the status of their claim or the country they are from (Antonipillai, 2015; Antonipillai, Baumann, Hunter, Wahoush & O'Shea, 2017). During the reforms, the Ontario provincial government also critiqued the rollbacks, condemning the federal government’s negligence, citing the negative impacts the reforms had had on the province as a whole (Harris & Zuberi, 2015). Although provincial governments tried to compensate for the loss of services, the true costs and consequences of the reforms of 2012 are still being understood. By limiting access to full coverage healthcare and health care services, the Canadian federal government violated the human rights of a vulnerable population. The reforms of 2012 had a plethora of potential negative consequences, not only for asylum seekers but also for Canadians. After reforms, coverage was still provided for immediate and urgent care; the reform in practice removed early diagnosis and screening for communicable diseases that could be effectively managed if caught early (Barnes, 2012; Harris & Zuberi, 2015). The mismanagement of disease is not only harmful for the population at risk but also the Canadian population at large (Harris & Zuberi, 2015).

Section 3. Method and Methodology

In this paper, I conduct secondary data analysis on interviews with service providers to understand the true implications and effects that the reforms of 2012 had on refugee claimant's health and well-being. I hypothesize that service providers and claimants experienced several barriers when trying to access and provide services due to the complications created by IFHP. Previous research on the changes made to the IFHP indicates some of the consequences to refugee populations following the services cutback (Barnes, 2012; Harris & Zuberi, 2015; McKeary & Newbold, 2010). On this premise, I extend my hypothesis and infer that *Bill*-C31 and the federal government was primarily responsible for the confusion and complexities of the system. In addition, I predict there were severe adverse effects on the health of refugee populations that occurred.

A. Methodology

As previously discussed, this study undertook a secondary data analysis with the aim to highlight prominent themes that emerged when service providers during the reforms of 2012. As with any body of research a framework was utilized to guide and shape the understanding of emerging themes. Based on the demographic being impacted by this research I chose to utilize the human rights framework to understand the findings from this study. I chose to utilize intersectionality as the guiding framework for the preliminary analysis (scoping review).

Human Rights

Previous research on refugee claimants in Canada has suggested that current Canadian policies have shifted and reformed to exclude vital groups based on national identities, hindering Canadian progress (Baines, 2017; Hein, 1993). The discourse that has surrounded *Bill C-31* and *IFHP* suggests that the grouping of individuals into separate categories of asylum seekers and providing different services based on countries of origin is a glaring human rights issue and is a form of hierarchical racism that deters successful policy production (Atak, Hudson & Nakache, 2018; Olsen et al., 2016).

Article 14 of the Universal Declaration of Human Rights states "(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution (2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of

the United Nations (United Nations, 1948). On this basis, it can be suggested that categorizing asylum seekers based on country of origin and utilizing one's country of origin as a reason to deny rights and services to certain groups of individuals is a glaring human rights issue. Furthermore, providing access to healthcare for certain groups of claimants and drastically reducing entitlements for other groups of asylum seekers is a direct breach of the *Canadian Charter of Rights and Freedoms*, 1982. The reforms of 2012 violate section seven "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (*Canadian Charter of Rights and Freedoms*, 1982, section 7), section twelve "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment" (*Canadian Charter of Rights and Freedoms*, 1982, section 12) and section (15) "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (*Canadian Charter of Rights and Freedoms*, 1982, section 15). Both the Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights will work as guiding documents for research, as the reforms of 2012 were enacted in spite of these documents. It should be noted that on July 4th, 2014, ruling by the Canadian federal court struck down the changes made to the IFHP as they were in direct violation of both section 15 and section 12 of the Canadian Charter of Rights and Freedoms. This ruling came two years after the changes were made (Beatson, 2016).

In line with the policy documents, "Harming refugee and Canadian health: the negative consequences of recent reforms to Canada's interim federal health program" (2014), will also be used as a guiding article for this paper. The authors of the article utilize the language of human rights and system inequity, to frame the reader's understanding of the IFHP. While conducting this analysis, the values and understandings of the human rights framework will guide my research and aid in interpreting any findings (Turner, 1993).

Intersectionality

Intersectionality was selected as an analytic framework to analyze the knowledge gained from the scoping review conducted in this study since refugee experiences are not a function of a single identity.

Intersectionality was developed using critical race and feminist theory and is useful in identifying, power, privilege, and oppression that influences people's lives. The concept of intersectionality first began as a way to understand the simultaneous interaction between being black and a woman (Crenshaw, 1990). Since its conception, the framework has been applied to other identities in order to understand people's social locations in society. Although there is no single definition of intersectionality as it can be applied to a variety of disciplines, its importance as a framework is clear as it considers multiple structures and helps to explain how society functions on a conceptual level (Gangamma & Shipman, 2018).

Refugees have several identities or memberships (race, gender, age) throughout society, which intersect at various crossroads, shaping their lives and circumstances (Cole, 2009). The memberships of intersectionality often have several stigmatizations that work to create surprising and unexpected inequities and inequalities throughout an individual's lifetime. The separation of refugees from their identity removes the understanding of their lived experiences (Gangamma & Shipman, 2018). Intersectionality as a framework works to conceptualize these experiences as distinct and understands the social and historical oppression of refugees' current social location (Gangamma & Shipman, 2018). Utilizing this framework in this scoping review was helpful in shaping inclusion and exclusion criteria. Intersectionality helped determine which studies would be essential in explaining the stories of refugee claimants, based on dates, study design, outcomes, and claimant populations. It also worked cohesively with the human rights framework, which was also used. Along with utilizing this framework in the scoping review, it was also used to understand the themes that became prominent throughout this study. Although not all themes of this study could be understood thoroughly through intersectionality some of the themes used intersectionality as a way to understand how individuals are positioned at a disadvantage in society.

Research Paradigm and Theoretical Paradigm.

The production of knowledge requires a paradigm by which to understand, interpret and disseminate research. Knowledge paradigms are a set of beliefs about how knowledge is created (Guba & Lincoln, 1994).

Paradigms shape the way we think and understand current issues in health, therefore allowing us to conduct research and shape adequate policy.

In line with the human rights framework, the methodology of this MRP uses both the ontological and epistemological assumptions of the transformative paradigm. The transformative paradigm addresses social oppression, social justice and politics at every level it occurs, positioning researchers at a point of social transformation (Mertens, 2014; Oliver, 1992; Reason, 1994). Based on the context of this research and its implication for human rights, the transformative paradigm offers cultural competency and understanding of different groups of marginalized people that other paradigms ignore, further addressing the lived experience of individuals who are being affected by specific social constraints and policies (Mertens, 2014). Similar to other paradigms, the transformative paradigm suggests that multiple realities exist (Mertens, 2014). The ontological belief of this paradigm suggests that giving priority to one reality over another is a type of privilege that is dangerous for marginalized peoples (Oliver, 1992; Reason, 1994). Drawing on current knowledge about refugee populations, this paradigm can extend to understand the lived experiences of refugees and the intersecting identities that position them in lower levels of power in society (Gangamma & Shipman, 2018). The argument, therefore, suggests that there must be a critical examination of ideological creations of oppressive social structures and policies. The epistemological assumptions question the construction of knowledge in relation to culture and power, and the nature of forming partnerships between researcher and communities (Mertens, 2007). The transformative paradigm considers who the creators of knowledge are and the legitimacy of the knowledge in society. For the purpose of this analysis, it is important to understand how knowledge is created and the purpose behind the knowledge being disseminated throughout the population. More specifically this paradigm works to question the dominant narratives and perceived realities and truths that have been socially constructed and are guiding society through the invisible hand (Mertens, 2014; Oliver, 1992; Reason, 1994).

Mertens (2007) examines the importance of the transformative paradigm in understanding culturally complex settings in society. This research works to understand the experience of refugees as a function of who they are in society and the oppression experienced through the inequitable legislature. Refugees and asylum seekers experience a variety of intersecting identities that place them in marginalized populations and

vulnerable positions in society. The role of the researcher in the position of power in this paradigm is to recognise the inequities and social injustice and share the responsibility of social change (Mertens, 2005; 2007). The transformative paradigm raises assumptions that underlie the research and enhances the human rights framework, which grounds this research (Mertens, 2014; 2007).

B. Method

i. Sample

Participants of this study included 17 health sector service providers (n=17). Service providers included, medical practitioners (n=9) administrators (n=5) and frontline staff (n=2). There was also one refugee claimant who participated (n = 1). Snowball sampling was used to recruit participants from a variety of different areas of practice in order to add depth to the research and provide a larger scope to the issue from a variety of perspectives. The participants' knowledge of refugee services and coverage ranged widely. Some were extremely knowledgeable, meaning that the service provider had constant interaction with refugees during and after the healthcare coverage rollbacks. Participants who had little to no interaction with refugees were also included in the sample in order to analyze the scope of their understanding while trying to gauge the scope of training offered to professionals during the reforms.

Participants were recruited by posters, emails, and word of mouth and through previous connections with researchers and primary investigators on the team (Dr. Anneke Rummens, Accessibility and costs of healthcare for refugee claimants following changes to the Interim Federal Health Program [IFHP], funded by the Canadian Institutes of Health Research [CIHR]). Each participant was given a full briefing of the nature of the study when they agreed to participate in the study. Each participant was given the scope and purpose of the study and was also given the opportunity to withdraw from the interview if they did not feel comfortable answering the questions. The anonymity of the participants was protected during the interview and transcription process. All names, work locations, and personal information were removed during the data transcription for data analysis. Participants were all interviewed by phone. Finally, participants had the opportunity to have a copy of the interview transcript if they requested one.

ii. Procedure

Participants were asked to complete a semi-structured interview with the primary investigator of the study. The questions in the interview were designed by the research team to add depth and understanding of how changes in the IFH program had affected health and health care for refugee claimants. The interview guide consisted of 8 questions in total, with 8 probing questions. The questions probed information regarding the participant's knowledge, their patients' and their own demographics, and experiences with patients and policy. The interview guide was semi-structured to enable participants to be prompted about their experiences while also allowing them to share any additional information or knowledge they may wish. Most interviews took approximately 30 minutes. A copy of the interview guide is presented in Appendix D of this document.

For the purpose of my MRP, I conducted a secondary data analysis on the interview transcripts. The interviews were coded for common themes. As previously mentioned, a scoping review on the impacts of *Bill C-31* was conducted and an initial coding list was generated. The themes emerged from reading the interviews and comparing content across the body of research and literature. Interviews were conducted until the point of saturation. The interviews were coded and analyzed using NVIVO 11. Twenty nodes were created and from those nodes, ten themes emerged as relevant. For the scope of this paper, findings from only three of the themes will be presented. The remaining themes will be presented in future papers.

Section 3: Findings

A. Scoping Review

A preliminary analysis was conducted in the form of a scoping review. The intended aim of the scoping review was to develop a critical policy analysis regarding the impact of *Bill C-31* on refugee populations in Canada. Through the introduction of *Bill C-31*, DCO claimants were no longer considered part of a vulnerable population since the DCO country of origin is often deemed "safe" and the claimants are deemed "capable". However, in accordance with international human rights law, Canada must provide DCO claimants asylum

(Baines, 2017). DCO claimants are deemed independent of the state, meaning they are not provided with government services and assistance. The purpose of the scoping review was to analyze the content literature available regarding the negative impacts *Bill C-31* had on refugees in Canada since its introduction (Atak et al., 2017). The aim of the research was to shed light on common themes and discourses and to find gaps in the literature.

With this concept in mind I formulated a question, which could be answered with Arksey and O'Malley's (2005) framework. Based on previous knowledge on the topic area and a general search I created a list of guiding questions (Figure 1, Appendix B) which worked to inform my inclusion and exclusion criteria. The final question research question asked:

"What existing literature is published on the impacts of Refugees in Canada after claimant policy reform and the introduction of Bill C-31 through a human rights perspective?"

The scoping review analyzed literature, pre- and post-reforms of 2012 in order to present a timeline of the impacts on refugees while telling the story of constant policy change in Canada. Intersectionality was selected as an analytic framework for the scoping review since all people, including refugees, are not a function of a single identity. Refugees have several identities or memberships (e.g. race, gender, age), which intersect at various crossroads, shaping their lives and circumstances (Cole, 2009). A human rights framework was selected as a second analytic framework since previous research on refugee claimants in Canada have suggested that current Canadian policies have shifted and reformed to exclude vital groups of individuals, which may serve to hinder Canadian progress as a country and in immigration and humanitarian causes (Olsen et al., 2016). This method for the scoping review was based on a paper by Arksey & O'Malley, 2005.

As demonstrated through Arksey and O'Malley's framework, the process of a scoping review was essential in exploring a new and fragmented area of research in order to understand the range or extent of available research on this topic. The aim of this scoping review was not to appraise the quality of studies but to provide greater conceptual clarity about this topic of *Bill C-31*. Arksey and O'Malley's (2005) five stages were followed to conduct this scoping review: the question focused on *Bill-C31* was identified; relevant studies were

identified; studies were selected; data were charted; data were collated, summarized, and the findings were reported. A similar study conducted by the Canadian Dental Association evaluating the oral health status of immigrant and refugee children in North America was used as an example of a scoping review (Reza et al., 2016).

Following the framework laid out by Arksey and O'Malley, I reviewed books, opinion pieces, grey literature, and opinion articles. Search terms were selected based on the research questions of the scoping review. The aim of this scoping review was to answer the following question "*What existing literature is published on the negative impacts on Refugees in Canada after claimant policy reform and the introduction of Bill C-31 through a human rights perspective?"* Based on this question I used key terms such as **Bill C-31* and *Negative Impacts, OR **Bill C-31* and *Refugee Health Impacts. Based on the inclusion and exclusion criteria that I created, I conducted three rounds of analysis before selecting the studies that I would analyze for the findings of this review. The review generated 19 articles. The articles consisted of critical discourse analyses, editorials, commentaries, and policy analyses but there was a range of theoretical and analytical frameworks utilized. Articles ranged from different years and had several different periodicals (journals), the most prominent being *Refugee*.

The scoping review identified similar themes among the articles. Three common themes emerged throughout the review: there is negative discourse surrounding refugees and refugee care after Bill C-31; mental illness has emerged as the most striking health outcome after this policy reform; and individuals should be questioning the legitimacy of *Bill C-31*, particularly when it comes to mandatory dentation of DCO asylum seekers. The full scoping review and analysis of the findings are presented in Appendix B of this paper.

First, after its introduction, *Bill C-31* created or caused the emergence of a negative discourse around asylum seekers. Several articles reported that at the time of its introduction with the current federal government, state relations with asylum seekers had been problematic but had also dramatically shifted to the overtly racist since the introduction of *Bill C-31* (Levine-Rasky, Beaudoin & St Clair, 2014). Canada continues to maintain its hospitable reputation around the globe, however, Canada's treatment, discourse and policy changes for asylum seekers leave a lot to be desired (Atak et al., 2018; George, 2006). During the reign of the Conservative federal

government, many of the policies reformed and re-enacted were deemed as violations to human rights and were overturned by supreme courts (Atak et al., 2017; Beatson, 2016). Politically driven media during that time portrayed refugees as threats to security and economic migrants, which shifted public attitudes (Wallace, 2018). Canada is currently focusing on its own wellbeing by resettling economic migrants instead of focusing its efforts on the global refugee crisis. Media framing has also shifted from negative portrayals of refugee claimants to slightly more humanitarian views of the population (Wallace, 2018).

Second, a common theme emerged around the mandatory detention of DCO asylum seekers. The scoping review found that many authors question the legitimacy of *Bill C-31* because it punishes asylum seekers for seeking a basic human right. Detention of migrants in Canada has increased to include migrants posing flight or security risks; those who do not have proven identities and are determined illegal or designated foreign nationals (DFN) over the age of 16. Individuals who are post-sentence; pre-removal offenders are transferred to prisons immediately and await deportation. Canada participates is a discretionary detention policy, where they focus on three specific groups of migrants: (1) "irregular migrants," or foreigners who have entered illegally; (2) asylum seekers prior to a final decision on their claims to protection; and (3) asylum seekers whose applications have been denied or delayed. Detention depends on whether migrants are eligible for parole, post bail or a decision can be made regarding removal, this process can cause tremendous strain on the psyche (Silverman, 2014).

Furthermore, the Bill does not consider human trafficking and punishes the victims (women, children) that are being trafficked. However, in accordance with *Bill C-31,* there is no immediate punishment on the traffickers. Although the act of trafficking is a crime, the immigration violations of being trafficked are a criminal offense, and the onus is put particularly on the victim. Traffickers are held accountable in accordance with different federal laws (Galloway, 2018). Several authors question the legitimacy of the Bill, they question whether it is a human rights issue, and note that academics and researchers should question the motivations behind *Bill C-31*: was it really put in place to deter abuse of the Canadian system (Antonipillai, Baumann, Hunter, Wahoush & O'Shea, 2018; Cleveland & Rousseau, 2012; Olsen et al., 2016; Silverman, 2014; Stevenson, 2018)?

Third, negative mental health outcomes also emerged as a common theme among refugee claimants. Unsurprisingly, the negative impacts of *Bill C-31* have created a complex system where claimants cannot access services readily and experience barriers when accessing health services depending on whether they are a DCO or non-DCO. The system complexities and the increase of imprisonment have caused an increase in the numbers of suicide, PTSD, and self-harm. Although much of the mental health outcomes can be attributed to forced detention (Atak et al., 2018), the complexity of the healthcare system could have played a role in exacerbating mental health issues since it has limited people's access to important mental healthcare (Cleveland & Rousseau, 2012; Gangamma & Shipman, 2018; Levine-Rasky, Beaudoin & St Clair, 2014). Understood through intersectionality and human rights framework, this group of claimants has experienced trauma and already has multiple memberships. Multiple memberships position people in vulnerable places in society. These social locations identify people through the race, gender, sexuality, religion, ethnicity, age, and ability. In the wake of social criticism, universalization of policies is no longer an option. The findings presented in this scoping review represent a cyclic approach to policymaking, whereby policymakers are assuming a one size fits all approach will be effective when making a decision that shapes people's lives. Considering the various levels of societal oppression associated with multiple memberships, we can infer from the scoping review that Bill C-31 was created in a vacuum without consideration of intersectional oppression. The denial that identities do not interact at a functional level, whereby each identity has a different and separate cause and the effect is in of itself acceptance of universality. Social structures that shape one's identity are seldom one type. The ignorance of producing a policy that ignores the cause and effect of intersectionality is a violation of human rights and further oppresses, vulnerable populations (Crenshaw, 1990).

The results of the scoping review are an example of a policy shaped with the disregard of intersectionality and human rights. The current discourse surrounding Bill C-31 through a human rights perspective suggests that Canada is creating patchwork policies that do not adequately serve the needs of the growing number of refugees entering Canada. Patchwork policies have created a greater number of inequities in services being provided by the Canadian government and by introducing Bill C-31, Canada in participating in hierarchical racism and abuse of an already vulnerable population. Furthermore, the negative consequences of

this Bill have manifested through poor mental health outcomes and have created a complex system to access services for claimants under this Bill. There is little to no research being done on the physical health of DCO specific refugees who are entering Canada under Bill C-31. The current research has identified the mental health effects of DCO claimants that are specifically being detained because of the reformed policy. Studies suggest that due to this reform negative discourse surrounding refugees and asylum seekers has increased, however there has been little quantifiable research in this area. Further research should be conducted on whether the complexities of the healthcare system are deterring access, and whether Bill C-31 has deterred abuse of the Canadian system.

In the case of refugee reform policy, policy-makers have ignored the fact that individuals who identify as refugees already identify at different and multiple memberships (race, gender, sexuality, religion, ethnicity, age, and ability). In addition, they have also experienced the effects of displacement which can be exacerbated by multiple identities. The intersections of race, gender ethnicity, and religion position refugees below the structures of privilege whereby disadvantages due to their social locations impact them in surprising and unexpected ways. (Cleveland & Rousseau, 2012; Crennshaw, 1990; Levine-Rasky, Beaudoin & St Clair, 2014; McKenzie, Tuck & Agic, 2014; Wales & Rashid, 2013).

In summary, the preliminary scoping review showed that *Bill C-31* (1) created a negative discourse surrounding refugees, bogus refugees and refugee care, (2) mental health was a significant health consequence after the policy reform specifically related to healthcare, (3) the legitimacy of *Bill C-31* should be questioned (Appendix C). In the following section, I present the findings of the current study related to three health equity themes: negative health effects on women; barriers to healthcare access (including language, fear and cost) and finally, significant medical bills and delayed care.

1: Potential Risks to Women's Health

The study found that some female participants experienced unique vulnerabilities because of reproductive health during the reforms of 2012, and the IFHP rollbacks. A participant described their experience of having a female patient leave after having a baby due to unexpected fees:

> …the hospital stay is for a 24-hour period [*mhm*], so if the patient delivers at 2 in the morning ok 5 in the morning generally they stay for 24 hours and leave at 7 in the morning. But if they don't have OHIP or, I don't think they consider, I don't think that'd be the case that someone with federal health coverage [*mhm*] but without OHIP if you sign out at midnight, then you're not charged the extra day. So a lot of patients will choose to leave at midnight [*so they'll leave.*…]. So when it comes to their baby, they'll leave or they'll be discharged and the nurses out of compassion will keep them in the hospital until they are fully recovered from their delivery … Um, but the babies are an issue, so at one point the babies were not receiving OHIP, the patients that did not have OHIP … covered under federal health and automatically get OHIP … I'm assuming …for a while … babies were not being covered… I think it has changed since. I think recently it has changed back to all the babies having coverage just because the administration is quite difficult.
>
> *Participant 16*

This participant went on to describe experiences with pregnancy and childbirth after the IFHP changes:

> …So midwifery, … those who don't have OHIP will often get sent to, um, midwives because the midwifery system is very different, they're covered, they get paid on a salary basis …. They were legislated, I think, in 1991 and so they are covered by the government federally …because we get paid fee for service but they get paid regardless. So when a patient doesn't have any coverage, sometimes they will be sent to a midwife. So I have seen many, many patients come into the hospital under a midwife that is covered under the Interim Federal Health and then when they need to be seen by an obstetrician, somebody is high risk, then we see them at that point. … So perhaps what we're seeing is that we're missing a lot of patients that would ordinarily be in the hospital, deliver in the hospital, but they are choosing to deliver at home so they don't have to worry about having their coverage … continue throughout their pregnancy.
>
> *Participant 16*

This participant also describes the experience of a pregnant woman who believed she was not covered for her delivery after the IFHP changes:

> Um, yeah so I mean we would spend a fair bit of time explaining uh coverage to people. Uh I remember having one patient who didn't follow-up with their specialist, um, because they felt specialists weren't covered, although they had no problems coming to see us. Um, we had an interesting case of a woman that was sent to us- not a patient of ours- but, um, her lawyer had sent her to our clinic recognizing that we work exclusively with refugees. And our nurse practitioner spent about two hours- she was 37 weeks pregnant, she had been followed by an obstetrician, and at the end of her pregnancy at 37 weeks, obstr- obstetrician said "well you've lost coverage, uh, come back next week but bring 3500 dollars with you," and she was aghast. Uh she spent- um she didn't have the money- she spent time approaching community health centers and midwives, and she even went to the hospital and tried to negotiate with them because she was terrified she was gonna have her child on the street. And finally came into our office and, you know, she spoke English she was very eloquent um, and you know through a number of phone calls including contacting her lawyer, we found out that she actually shouldn't have had her coverage changed, and that was an administrative mistake. But she was able to navigate the system and find people who were willing to help her sort that out. You know I'm very concerned there are people who don't speak English, who won't have the same capacity to be able to approach their lawyer or their physician or someone else's physician to determine their coverage. So things worked out fine for her, but we've seen a number of those cases and I think for a lot of those people uh, you know, I'm afraid that they didn't get the care they should have had. So I think for patients to even understand whether they should be covered or not, uh is incredibly complicated. If physicians don't understand the system you can imagine for many refugees and refugee claimants, given the

> stressors they live under, given the language issues, uh, given their concern about accessing, uh or, or addressing issues with, with government bodies uh I think it becomes very difficult for them to clarify their coverage. And that's certainly what we were seeing.
>
> *Participant 11*

The following participant describes their difficulties when trying to access care for different health specialists:

> "Um, I don't know, like I, I mean I had a, an endocrinologist that uh would, he stopped seeing his Type 1 diabetic client. [*Mhm, kay*] I had an obs – a high risk obstetrician that, uh once they found out that the patient was IFH, refused to see this person even though she was, uh, she was high risk and she was 32 weeks pregnant. Um, I had a, a surgeon that was going to be, I guess he was an ear, nose and throat specialist, that was gonna be doing surgery, I think it was a, I think it was an ENT that was gonna be doing a tonsillectomy I believe it was. Um, oh I'm sorry, it was a timpanoplasty to repair an eardrum in a child and that was cancelled. [*Mmkay*] Um, and uh, can't remember, uh, all of the specialties, but I don't recall feeling like there was just one particular specialty that was, that was refusing people now"
>
> *Participant 03*

Finally, another participant describes a participant being denied care because she was unable to pay for care and was not covered:

> "Okay [*yeah*], so th-th-this patient uh, this woman presented in labour. Um, and had requested an epidural for labour analgesia. [*Yeah*] When the anesthesiologist came to attend to her, um, he was looking for documentation of, of uh, insurance. Uh didn't see OHIP card and asked, I believe, for IFH-type payment uh, and it was unclear at that point, whether she knew, she knew she was covered or didn't. Uh, the physician certainly didn't know and at that point, uh, I believe, uh, a payment was requested up front or at least after the fact. Uh, in other words, your ins- you don't

> have insurance to pay for this service, [*mhm*] um [*mhm*] we'll provide the service but you have to pay for it. [*Mhm*] I believe that's the discussion that took place. [*Right*] The patient said, "I can't pay for it" or, ei-ei-either "I can't pay for it" or "I won't be able to pay for it." Um, and-and with that, uh th-the service was refused"

When asked if the participant was denied the epidural because she could not pay the participant replied:

> "An epidural yeah, for labour, yeah"
>
> *Participant 04*

2: Barriers to Healthcare Access

Participants discussed multiple barriers to healthcare access including language, fear, and cost. When asked about the systemic factors that contribute to blocking or promoting access to health care for this population, participant 14 describes the way in which language is a large barrier to care:

> Language is a big barrier. Hospitals are not using their language lines. [I] find they have policies and have statements around respect etc. and dignity and diversity and on-going not using language lines. Patients ask for interpretation and don't get it. Those on the floor don't know about using language lines and about interpretation…I had experience and said would use teenage daughter to interpret and it was around cancer and not appropriate to use child to provide such sensitive interpretation. Don't know how they are providing health care to such vulnerable population without interpretation. Had client who took young child (under 3) to Emerg, wouldn't provide interpretation and she had no English. Appreciate it's difficult in Emerg but I've seen that when they are admitted they are not accessing interpretation. Don't see how you can be giving quality care if you don't understand your patient.
>
> *Participant 14*

In line with participant 14, participant 05 shares similar sentiments regarding language as a barrier to healthcare access:

> "Um, [*it's very abstract question I know*] yeah, I'm trying to think, okay. Well I th- I, the, the one that comes to mind that's kind of obvious and I guess it's 'cause of the population I work with [*mm*] would be, the English language barrier, [*mhm*] right? [*Mhm*] Um, I mean we provide interpreters here whether beyond site or in person- that service is always available for our clients. [*Mhm*] But that's not necessarily the case when we refer them elsewhere, so I find the English language barrier is a huge, um, poses a h- is, is a huge barrier. [*Mhm*] Because if you don't have family members who can translate French, who can translate- 'cause sometimes, some individuals will specify - or specialists or what have you - that the patient bring their own interpreter. [*Mhm*] Which I think isn't the best thing, because they're not trained, right?"

Participant 17 discussed the fear of having to pay and of being reported as barriers to accessing healthcare for refugees and the ways in which their service helps to deal with that:

> "So like the transportation, we talked about … Transportation cost. Um, also fear of the system I think…Because like fear of the system being reported, so scared to go unless they really have to. Um, our patients I feel not as much once they arrive to our clinic. Before that you can tell they are scared to go to the hospital and stuff because they are scared they have to pay, and, which is a real fear. Um, fear of being reported, but if they go through us, they know, like they feel more comfortable going through us. They um, they trust the services we provide and so if we say go to this place they know we'll take care of it or there's someone to call if something does go wrong … I can't think of the other ones right now"
>
> *Participant 17*

Participant 3 discusses systemic barriers that are blocking or promoting access to health services, for refugee populations:

> "I mean this population had barriers prior to the cuts [*mhm*], and all of those barriers still exist, so there's you know, there's language barriers, there's income barriers, there's all of the socia-social determinants of health. There's, there's racism, there's judgment about people's religion, um, there's judgment about the way people are dressed, you know there's so many layers of barriers for these kinds to start with. Not to mention some of them have never met a medical provider in their lives, um and some people you know are not aware of preventative care, they come from systems where they may have just seen a specialist when they had you know chest pain, they would go see a cardiologist but they've never seen primary care providers, so, there was a lot of barriers to kind of start with, and the thing is that um, it, it's always- it's been known for a long time that it's difficult getting this particular population to access healthcare in the way that we would like to, because um, they're just not used to it, like people are used to just going to the emergency, I guess, if they have a problem rather than accessing primary care. So that, that all existed prior to the cuts, but since the cuts, yes, I mean I phoned, I phoned all of the walk-in clinics in [CI2] after uh, the cuts in June 2014 and I just asked um the secretaries like, "you know I'm phoning just to know if you would accept a client with IFH," and uh, there was I believe it was seven or nine out of thirty-three I think that were accepting clients with IFH. And a couple of those had, you know asterisk beside them, like they would accept a patient but the patient still had to pay seventy dollars or whatever. [*Mhm*] So the uh amount of care that was available to patients for primary care was really limited by the cuts"
>
> *Participant 03*

This participant describes a refugee claimant woman that refused care because of lack of coverage and cost. She chose to refuse immediate treatment and to wait for her condition to become emergent before accessing care:

> "But I had another one literally just yesterday, a woman who was diagnosed not with anglo closure glaucoma but with a very, very narrow angled that likely, that could very easily become an anglo closure glaucoma so an urgent sort of emergent about to lose of your vision kind of a thing [*mhm*] and the treatment literally, uh I mean a laser iridotomy would be the treatment which is quite literally sit in an ophthalmologist's office, they aim a laser at the, at your eye and press a button and it takes maybe a few seconds. I've seen it done, uh, but the ophthalmologist won't do it –
>
> Iridotomy. I-R-I-D-O-T-O-M-Y. It's basically, the coloured part of your eye just above the pupil [*yeah*] you pop a hole in it, and it's paper thin so you wouldn't even see it. It's tiny as anything [*yeah*] but it relieves any risk of pressure in your eye [*mhm*] uh, and it takes about a second. They just, with a very magnified camera, they have a little see, you sit down, you look into their scope, they look at your eye under magnification, aim their little laser, press the button, done. But, the ophthalmologist basically said listen, I will happily take the money that your clinic has paid me for the consult, but I'm not going to do this procedure because I'm not going to be able to bill for it, so forget it. And the patient basically said well, listen, I don't want to be caught again trying to find a specialist who will be willing to treat me. Worse case, if I get excruciating pain in my eye and my vision starts to go, I'll run to the emergency room and hope for the best"
>
> *Participant 20*

Finally, when asked to reflect on the differences pre- and post-reform, another participant pointed out how people became afraid and how it interrupted their medical care:

> "…people just got, I think, a little bit more afraid once they knew that there was no coverage for them. Um, they didn't have IFH … so that became a bit of a problem … they had coverage and then they didn't. So they were claimants and then all of a sudden they weren't covered, and that meant, you know, if you were in the middle of a specialist thing or if you sent them for

> something, um, they just, you couldn't, they didn't even get a call sometimes that they weren't covered. So that they went to appointments, and they couldn't get into the appointment, so it was kind of a mess"
>
> *Participant 19*

3: Significant Medical Bills and Delayed Care

When asked if there were health consequences when coverage was lost, one participant personally experienced additional health compromises due to higher than expected significant medical bills, unexpected medical bills, and delayed care.

> "It definitely was very stressful, … I lost weight, … um sleepless nights just wondering what would happen if I did get even sicker … or someone else in my family in a similar situation. … especially because, uh from what I understand, it's a very narrow scope of things which are covered. Like HIV or tuberculosis you literally, or malaria I think, … you almost literally have to be dying to be covered … under the rules, whereas, and so I wouldn't want to have to be in that situation to be covered … when I can just be healthy and covered for minor things. So there was a lot of concern for myself and my family in case they found themselves ill, unable to pay it, … um, it was a stressful time for everyone.
>
> *Participant 1*

In a similar way, participant 17 discussed a claimant's experience of not being able to access care:

> "There was another woman who came through; I don't remember how old she is. She's also Indian, maybe Pakistani. She's South Asian …she had diabetes and it was really not well managed … She looked a lot older than she was, but I think she was probably in her 60s. Um, but she, she was the one that we were trying to get in for, to the hospital because her kidneys were failing. And, um, she had public health and safety, but we couldn't get, we couldn't get the

care she needed. She couldn't get to the hospital basically … we tried to get her into the hospital and we just couldn't because of the delay in getting the OTHP forms."

"…there was another one, we wrote a letter and got her, her IFH back. Um, I forget why, she needed an MRI, I don't remember why. This is in November um 2014, um, and it was right after the whole Temporary IFH thing that happened. So they got their IFH back right before the MRI, so they were very excited, and they came and told us about it, and they go for the MRI and that was the one they said because it was 8pm so it wasn't online, so that's, so they ended up just cancelling that appointment, which was booked like 2 or 3 months in advance. And yeah, we told them that the only reason that we were able to book it was because they had IFH [*mhm*], and when their IFH ended or expired – um….I don't know what happened. Something happened to their claim, so the IFH ended up, um, expiring, um, and they got it back because of her condition and we wrote a letter and got it back for them, and then, yeah"

Participant 17

Participant 19 describes a situation is which the child experienced a delay in care due to coverage:

"Um…but essentially what happened was, um, you know, this kid has like an anatomic thing that he needed to see a surgeon for [*mhm*]. Um, and so, you know, we sent the referral off to their, to their um, to our, our local hospital to see if they'd get done and it came back that no, they wouldn't see this child because they didn't have coverage which was this whole so then you have to go back into the IFH system to see, you know, do they have coverage, don't they have coverage. They do have coverage, so you send it back to the surgeon and say this person has health coverage, um, you know, and that actually took months, like it just took months for that to get sorted, that kind of back and forth [*mhm*]. Um, you know this person has coverage, or I don't think they do, and the onus is on you, like as the person that is referring them. Like, um, I don't know what happens at the hospital system why they can't or won't

> check to see if someone has coverage. So it's just like nope, this person doesn't have coverage, we're not seeing them. And I'm like, I'm pretty sure you could look this up and figure this out [*yeah*]. Like it's not, like I, which I think is again, speaks to that kind of – well, this isn't my problem, if you want this person to be seen you figure out if this person has coverage [*right*], so I'm just going to say no"

When asked if there were implications for the child, the participant responded with:

> "I mean it was delay in care, quite frankly. It was the delay in them getting seen. You know they had endure whatever symptoms they were enduring longer than they needed to"
>
> *Participant 19*

Finally, participant 12 describes situations where claimants delay care due to significant costs and the repercussions of delayed care:

> "Yeah, uh that's happened a few times but only a handful of times [*mhm*] because the population is a very healthy population, [*mhm*] and also because the problem is they don't show up right away. [*Mhm*] So if somebody is not getting care for their cholesterol or whatever it is, that's not gonna show up in the emergency today, [*mhm*] the impacts of that system is, i- are going to appear in five, ten, fifteen, twenty years. In terms of what I see, what I see is for example, people who present because they've avoided dealing with a cost for a very long period of time- something like a- [*mhm*] and then, you know, I haven't had cases where it turns into tuberculosis, but suddenly, you kind of are, are gaming things a little bit so that you can do things, um, by claiming this, "oh this might be tubercular." [*Mhm*] So for example, for the x-ray, I could do it one of two ways- I can just write, "oh I want an x-ray to rule out pneumonia," or I can say, "I believe it's tubercular." [*Mhm*] And then just not even have to worry about it, um… Yeah so those cases do exist"
>
> *Participant 12*

Section 4: Discussion, Conclusion and Recommendations.

a. Discussion

This study examined the effects on refugee claimants and service providers after the reforms to the IFHP. Despite, the Supreme Court ruling to strike down the changes, the reforms had consequences to refugee claimant health, healthcare providers and more broadly Canadians on a social, economic and health level (Harris & Zuberi, 2015). The results of this study echoed major systematic barriers outlined in other literature. Previous authors in the field have highlighted language, cost and risks to women's health as prominent themes (Antonipillai, 2018; Barnes, 2013; Harris & Zuberi, 2015; McKeary & Newbold, 2010; Stevenson, 2018). In the following section each finding will be discussed in depth from a human rights perspective.

Finding 1: Potential Risk to Women's Health

By unpacking the consequences of the IFHP policy reform, we are able to better understand the unique health barriers experienced by refugee populations and specific consequences of this human rights violation that occurred in 2012. During the IFHP cutbacks, navigating the challenging terrain of the Canadian healthcare system became increasingly difficult. This study found that women, particularly pregnant women, experienced situational barriers when trying to access healthcare, particularly reproductive care after the reforms of 2012 (Appendix E). Echoing research on refugee women's healthcare, this study found that women experienced delayed care for pregnancy, were denied care due to costs of healthcare and preventive care was denied which further exacerbated their health conditions (Baines, 2017).

The findings of this study, outline several experiences of women, which were put at risk due to the *IFHP* reforms. In several situations outlined by participants, women identified the challenges they experienced due to the confusion of the healthcare system during the reforms. Participants of the study identified several risks to women's reproductive health, however they did not directly outline the outcomes of the women's experiences. Although no outcomes were identified, risks were identified. The risks that were found in this study echo the

challenges associated with patchwork policy creation, and cuts to the healthcare system. In many cases, risks and the associated challenges of these risks, for instances stress, are enough to worsen the reproductive health of women seeking healthcare during this period of time

Participant 16 highlights that many pregnant women opt to deliver at home since they are concerned about coverage and cost of care. This concern creates a cycle of complications for healthcare practitioners and patients, whereby immediate care for those women who require it is not provided. Lack of access to maternal care can create several complications for expectant mothers that lead to larger health concerns down the line. Due to the time-sensitive nature of pregnancy and perinatal care, the cuts to coverage created more health complications for expectant mothers (Gagnon et al., 2013; Stewart, De Souza, & Yudin, 2018). Moreover, the reforms also created health concerns for their infant, as prenatal care and postnatal care is vital to the health of newborns (Gagnon et al., 2007). The changes to the IFHP included the decrease of obstetric services covered for women in this program; moreover, it also decreased preventive healthcare coverage to certain groups of claimants (Kandasamy et al., 2014). It can be inferred that by placing the mothers at risk, the federal government also placed their children at risk. Without adequate care and coverage, mothers and their infants will likely experience negative health impacts (Samon & Hui, 2012).

In line with this finding, Kandasamy, and colleagues (2014), also identified that refugee status increased the risk of negative health outcomes for pregnant women. The risk increased by region of origin (Sub-Saharan African highest risk), multiparous refugee women had increased risk when compared to their counterpart, and the rates of Caesarean sections doubled if the woman was a refugee. Additionally, mirroring the findings of this study, they found that care was delayed five-fold for refugee women relative to non-refugee women (Kandasamy et al., 2014).

Lack of maternal, prenatal and preventive care constitutes a glaring human rights violation. In fact, Article 25 of the Universal Declaration of Human Rights states: (1) “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness,

disability, widowhood, old age or other lack of livelihood in circumstances beyond his control, (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection" (United Nations, 1948). In line with Article 25, this study identified that by creating these complex barriers, Canada violated its international agreement to provide adequate healthcare and protection to both mother and child. This study clearly identified that no special care provided to mother or child during the IFHP cutbacks depending on the category the claimant belonged to. In fact, this study found that the Conservative Federal Government placed women in such a vulnerable position during the reforms, that they felt like the only option would be to not seek the necessary and essential care they required but in fact refuse care, and opt for home births. The risks associated with opting of homes in several cases exacerbated these women's conditions placing them in a position of worse health, and endangering the life of their children.

By denying or delaying women access to care through the reduction of coverage or the fear of persecution, the federal government fosters an environment of poor prenatal care leading to future health complications for both mother and baby. Several studies indicate the strong link between prenatal care and future health for mother and child (Akter, Davies, Rich, & Inder, 2018). Mothers positioned in vulnerable social locations often do not have access to essential medicines and experience higher rates of drug abuse (Guruge, Sidani, Illesinghe, Younes, Bukhari, Altenberg, & Fredericks, 2018). Furthermore, vulnerable populations often experience higher rates of chronic disease that can create complications during birth (Guruge, 2018; Nies, Lim, Fanning & Tavanier, 2016). In line with this idea, providing coverage for only essential and necessary conditions for a population that is prone to high rates of chronic disease and drug use is a glaring oversight (Nies et al., 2016). Several studies indicate the known risk associated with refugee women's health (e.g. diabetes, HIV) (Gangnon et al., 2013; Kandasamy et al., 2014). Defunding a vulnerable group prone to health complications is a major risk that results in a ripple effect of additional and costly care (Harris & Zuberi, 2015; Olsen et al., 2016). One of our findings identified that expectant mothers will leave postpartum care against the medical direction. Although there was no indication of a negative outcome, the risk associated with leaving again medical direction is high. Mothers who opt to leave the hospital early and not stay for the entire doctor recommended bed rest period are also expected to experience greater complications and may have to return to

the hospital. If patients have to return to seek additional care, the returns are often costly and the woman is at greater risk for illness (Barnes, 2013 Stewart et al., 2018 Winn, Hetherington & Tough, 2018;).

The reduction in insurance coverage can also be linked to population health issues for Canadians (Harris & Zuberi, 2015). Before the reforms of 2012, refugees were entitled to and covered for specific preventive care that would help identify and eliminate healthcare issues before they would become a risk to the general population (Kandasamy et al., 2014; Olsen et al., 2016). After the reforms, care was only provided for diseases identified as a risk to the Canadian population by the federal government, for example, tuberculosis (Harris & Zuberi, 2015). Moreover, certain coverage was only provided if it was deemed "necessary and essential" (Harris & Zuberi, 2015). Again, not only is this a human rights violation, as it breaches Canada's agreement with the Universal Declaration of Human Rights, it also violates Canada's own charter, the *Canadian Charter of Rights and Freedoms,* particularly section 15 (Olsen et al., 2016).

Section 15 states: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (*Canadian Charter of Rights and Freedoms,* 1982, section 15). By reforming the *IFHP* and providing care coverage to certain groups of claimants, Canada has violated its own laws. The study found that equal protection and benefits were provided only to certain groups of people, solely based on country of origin, further violating human rights protocols, and committing acts of hierarchical racism.

Finding 2: Barriers to Healthcare Access (a) Language (b) Cost (c) Fear

The study found that there were multiple barriers to healthcare access in the form of (a) Language (b) Poverty (c) Fear. These findings are significant and expected when considering the population. Both service providers and claimants interviewed in this study indicated that these are among the barriers experienced by refugees trying to access healthcare in 2012 post-IFHP.

These barriers are closely linked. For instance, many refugees migrate from different parts of the world, where English is not their primary language. This is a bigger issue for refugee claimants than other newcomers to Canada. McKeary and Newbold (2010) outline the importance of addressing the health experiences of refugees, as they are separate from those of immigrants. They identify the language and cultural competency as prominent systematic barriers for refugee claimants in Canada (McKeary & Newbold, 2010). The authors argue that although the language is not a refugee-specific issue, they are more likely to be illiterate, and have a lack of vocabulary which could complicate their diagnosis and care instructions (McKeary & Newbold, 2010).

Language is a crucial factor when trying to access healthcare, as describing symptoms to a healthcare professional is essential for diagnostics (Lum, Swartz & Kwan, 2016; Peled, 2018; Vermette, Shetgiri, Zuheiri, & Flores, 2015). Additionally, due to policy changes claimants often did not know whether they were covered by the new IFHP. This proved to be incredibly problematic since claimants could be hit with unexpected costs. If claimants spoke English or used a translator, an administrator would potentially be able to explain the cuts.

Language is also linked to access to transportation, as it is to the experiences of cost and fear, which also emerged as prominent themes in this study. Participants indicated that refugees who have a hard time with language also experience barriers with transportation since language is an essential skill for navigation throughout the city. Claimants may be unable to access healthcare because they are cannot get around the city or province. This is not surprising, as transportation is often a barrier for marginalized populations (Kalich, Heinemann & Ghahari, 2016; Vermette et al., 2015). Transportation in any new country can be expensive and confusing. Refugee populations can experience various degrees of poverty when entering a host country. Paying for transportation in any form (public or private) can be costly and intimidating (McKeary & Newbold, 2010).

Fear is also a theme that emerged during interviews. For instance, participants indicated that claimants fear the system, persecution, and the possibility of complications due to their circumstance. Furthermore, during the IFHP cutbacks claimants feared to have to pay. As identified by participant 17, this fear was real. Depending on the type of coverage they qualified for, more than half of claimants that sought care during the reforms were

at risk of having to pay for their care (Harris & Zuberi, 2015). As previously discussed, many claimants come to the Global North with nothing, and having to pay the costs of care can create a circumstance of debt and even criminality if they cannot continue to pay (Harris & Zuberi, 2015).

This finding is incredibly problematic on an ethical and legal level, as it violates basic human rights, and identifies that Canada was, in fact, breaking several international and national laws during the cuts of 2012. For example, by restructuring the health care system, Canada was in direct violation of Article 25 "(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (United Nations, 1948).

In relation to *Article 25*, political propaganda framed refugee claimants as economic migrants eager and willing to take advantage of entitlements that Canadians are not entitled to (Harris & Zuberi, 2015). In the name of fiscal austerity, a culture of distrust was legitimized to protect 'good citizens' and the Canadian economy. Refugee claimants are disregarded as "good citizens" since most do not contribute to the labor market but instead take entitlements they are undeserving of. In line with *Article 25*, entitlements are basic rights that have been internationally and nationally agreed upon, regardless of person societal contributions (Kalich et al., 2016).

Finding 3: Significant Medical Bills and Delayed Care

Due to the cuts made to the IFHP, claimants experienced significant medical bills and delayed care that often led to additional health impacts. Participant 1 indicated that after being treated and unknowingly billed for treatment, they experienced significant amounts of stress, weight loss and sleepless nights. This experience sums up the complications that occurred during this reform. Claimants may be unaware of the costs they would incur. Refugee claimants that had been covered were no longer covered and once the treatment was complete, claimants were unknowingly billed for their care. The delay of care may have impacted their health, as the complications of the system sometimes created numerous delays in treatment and follow-ups.

Participant 12, discusses experiences where participants delay their care as a way to avoid the cost of healthcare due to lack of coverage. In line with this finding, Harris and Zuberi (2012) discuss similar situations whereby claimants will experience a denial of care or experience resistance from health professionals which will delay them from seeking care, even in emergent situations. Echoing the experience of participant 12, delaying or preventing care of emergent or even preventative care is a safety risks that extends beyond just refugee populations (Harris & Zuberi, 2012; Barnes 2012). The outcomes of preventive care and early identification are vital in ensuring the health of not only refugee populations but also the Canadian population (Wales, 2010).

The changes to the IFHP not only created complications for claimants, health professionals and administrative staff, but it also created inefficiency and cost complications for the provincial governments (Harris & Zuberi; 2015). Indicated in the 2012 auditor's report, much of the cost was shifted from the federal government to the provincial government (CHA, 2012). In fact, the federal government has failed to realize the cost-effectiveness of providing preventive healthcare coverage which can result is high fiscal costs and long term negative economic and social consequences (Baines, 2013; Barnes, 2012; Wales, 2010) These complications, coupled with the human rights issues, whereby "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (Section 15, Canadian Chart of Human Rights and Freedoms), are clear indications that the cuts to the IFHP had negative consequences.

It is not entirely clear why the Canadian federal government implemented these cutbacks in 2012. The government asserted that the primary intention of these reforms was to deter abuse of the immigration system. To further elevate these ideas about conserving taxpayer dollars and protecting Canadian populations against security threats were invoked. The results of this study call into question the underlying motivations of the Canadian federal government during the reforms of 2012.

The cuts to the IFHP created more complications and higher potential costs to the system both at the provincial and federal level. Furthermore, as outlined by the findings, there was less access to healthcare unless

someone could pay out of pocket. A reduction in usage does not correlate to the deterrence of abuse. The changes to the IFHP likely undermined the refugee experience and deterred asylum seekers in seeking refuge, which likely compromised the safety of many migrants around the globe. The complications created by inaccurate assumptions and problematic reforms are extremely troubling. The reforms of 2012 created less equity and victimized a vulnerable population by neglecting human rights and ignoring Canada's own international responsibilities when the policy was reformed.

Conclusion

The reforms made by the Canadian federal government to the IFHP in 2012 may have had significant adverse health effects on refugee claimants during that period of time. This study found multiple themes that emerged as prominent including risks to women's health; barriers to healthcare access (a) language (b) cost (c) fear; and finally, significant medical bills and delayed care led to additional health concerns.

During the reform of 2012, the federal government created barriers to accessing health care that fundamentally endangered refugee claimants and refugees, which created lasting adverse risks and health outcomes. The cuts to federal healthcare may have created many consequences for the health of refugee claimants but also created complications for all refugees regardless of status. Due to the complications of the system during the reforms, refugees in any status experienced delays and barriers when accessing healthcare, and risks to their own health. Although the implications and experiences of refugees varied to some degree based on their status, this study did highlight the experiences and various risks that were faced by them during this period of time. The reforms were not only a form of negligence but also violated principles of international and national human rights and the Canadian Charter of Rights and Freedoms. Although the prominent discourse of the reforms was that it was to deter abuse and save Canadian's taxpayer money, the cuts, in fact, had serious repercussions and negative health consequences for all claimants and by proxy all Canadians. The reforms created complex barriers and a patchwork policy system where both claimants and health professions could not

access or offer optimal care. The negative and inequitable outcomes of this policy were avoidable. The results of this study are clear: cuts to healthcare at any level are harmful and contributes to the poor health of refugees and vulnerable people.

Recommendations

Since the reforms of 2012, there has been a change in Federal and Provincial Governments in Canada. Although the cuts to the IFHP have been overturned, and full benefits (pre-reforms) have been reinstated, recommendations can still be made for future policy creation. Positive steps have been made with the current federal government, increasing funding by $283 million over the next two years (Chen, Gruben, & Liew, 2018). This follows in line with an ongoing program in which both researchers and health practitioners are still identifying gaps in healthcare coverage, while continuing to address the confusion and injustice that occurred after the reforms of 2012 (Chen, Gruben & Liew, 2018).

On this basis, and echoing the remarks of others who have examined this subject, the IFHP should expand coverage, and work to serve the unique needs of refugees, refugee claimants and other vulnerable people (Harris & Zuberi, 2015). The federal government at its fundamental level should avoid this “one size fits all” metaphor and extend its beneficiaries with services to address mental health and trauma (Chen, Gruben & Liew, 2018). In line with idea, the IFHP should consider greater coverage for care. There should also be consideration for language as a major barrier to healthcare of many vulnerable people. With this consideration the federal government should work with healthcare professionals, practitioners and frontline staff to find solutions to this highly examined issue (Chen, Gruben & Liew, 2018; Nakhaie, 2018; McKeary & Newbold, 2010).

With the impending election scheduled in October 2020, the Federal Government should consider its international and national commitment to human rights before reforming policies. In an effort to have a history not repeat itself, the Federal Government should learn from the reforms to the IFHP and implement a policy that is equitable in all facets of its manifestation. The current government should overturn harsh policies like Bill C-31 that are still implemented to date and recognize the importance of having progressive policies that respect

and foster human rights. Governments should consider the barriers outlined above and create policies that are not restrictive to particular populations. Furthermore, the government should consider their own motivations and biases when creating policies and implementing cuts to funding. If Canada wants to maintain its global reputation of a safe place for refugees, they should create policies that are inclusive and not victimizing of refugee populations.

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