
Impacts of the Interim Federal Health Program on healthcare access and provision for refugees and refugee claimants in Canada: a stakeholder analysis



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Refugees and refugee claimants experience unique health needs upon arrival in Canada as a result of hardships and trauma associated with forced migration and the assignment of precarious legal status by the host country. In 2012, retrenchments to Canada's refugee policy were introduced through regulatory changes to the Interim Federal Health Program (IFHP), generating concerns among healthcare professionals and other stakeholders affected by the reforms. These major policy reforms implemented constraints on some categories of refugees and refugee claimants, deeming them ineligible to access healthcare offered to other categories of claimants and Convention refugees.¹ In 2012, the CIC reported 20,469 in-land applications were received by the Canadian government while only 10,380 applications were submitted in 2013. This is the lowest number of refugee claimants applying for asylum within 20 years of available data in Canada.²

A legal challenge launched by the Canadian Doctors for Refugee Care (CDRC) on the basis of violating section 12 of the Charter of Rights and Freedoms, successfully appealed to the federal court that the cuts to the IFHP was a form of "cruel and unusual" treatment.³ Therefore, on November 4th 2014, the Federal Government of Canada announced the introduction of "Temporary measures for the Interim Federal

Health Program." This new program reform was not a full reversal of the cuts made in 2012.⁴ It did restore access to some key healthcare services and provisions for refugees and refugee claimants, however it created more complex funding rules and levels of coverage. The reforms provide 6 varying levels of health insurance in which certain groups of refugee claimants and refugees are still underinsured or uninsured unless their condition is a concern of public health or public safety.

Moreover, due to poor or non-existent knowledge translation or policy implementation efforts, it can be assumed that certain healthcare professionals or workers may not even be aware of the 2014 changes, and may still be implementing the 2012 cuts. The success or failure of many programs is dependent on policy subsystems, consisting of key stakeholders, and their involvement with the decision-making and implementation process. In reality there are only assumptions on what the current situation regarding refugee claimant access to services and professional provision of healthcare. Therefore, more information is needed to map out the impact of the 2014 IFHP reforms on this policy subsystem consisting of diverse stakeholders.

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This study examined the acceptability of the IFHP 2014 reforms as well as the extent to which the policy's intermediate goals were achieved by collecting stakeholder perspectives on the effectiveness of the recent IFHP reforms, and their position with regards to the current program. The primary outcome was to obtain the perspectives and experiences of diverse refugee claimant health stakeholders impacted by the IFHP reforms, particularly focusing on the 2014 changes. The secondary objective was to examine how effectively the 2014 changes were being adopted and implemented to improve access and provision of healthcare for this vulnerable group by interviewing individuals belonging to four stakeholder groups, including refugees and refugee claimants, civil society organizations, professionals and practitioners as well as policy makers and government officials, all who have a vested interest in and are impacted by the IFHP.

Global Health Relevancy

Forced migration is growing in volume and significance because of endemic violence and human rights violations. Currently, the UNHCR reports that there are 19.5 million refugees of the 59.5 million forcibly displaced migrants, worldwide (UNHCR, 2015). The threat of an increased influx of refugees into the state is accompanied by state concerns of increased cultural and political disruptions that challenge the identity of the state and erode the nation-state's sovereignty (Mandel, 1997). As refugees maintain the right to seek asylum in industrialized countries, tensions between state sovereignty and humanitarian legal obligations of the host state arise.

As a result, the state implements national immigration and refugee policies which aim to protect state sovereignty and exclude certain migrants, such as refugee claimants, by distinguishing the identity of refugee claimants from that of the nation. State imposed restrictions have severely limited many global movements of refugees into Canada. These restrictions have created clearly defining categories for migrants and eliminated essential social supports, such as healthcare services. As a result, certain categories of migrants are being excluded from nation-states and a portion of inland refugee claimants, the most vulnerable population of non-status migrants, are denied access to basic healthcare services.