

Major Research Paper

Redefining Refugees in Canada: Comparing Policy Frames for Refugee Health Care Policy in

Canada and the United States

Vilma Veronica Rivera Perez

Student Number: 6801990

Supervisor: Professor Patrick Fafard

University of Ottawa

Graduate School of Public and International Affairs

Date: August 15, 2014

Table of Contents

- I. Introduction
- II. Methods
- III. Comparative Politics Framework
- IV. Refugee Health Care in the United States
- V. Refugee Health Care in Canada
- VI. Framing Legitimate and Illegitimate Refugees in the United States and Canada
- VII. Conclusion

Abstract

In 2012 the Government of Canada announced a series of changes to the Interim Federal Health Program responsible for health insurance for refugees and asylum seekers in Canada. The reform restricts medical coverage for certain groups, including privately sponsored refugees and asylum seekers with pending or denied decisions. Despite strong opposition from medical professionals, refugee advocates and provincial governments, the Government defended its decision on the grounds that the previous system was “too generous” and it would be unfair to grant medical insurance coverage beyond that offered to Canadians. Similarly, in the United States the Refugee Medical Assistance Program also distinguishes health coverage eligibility between refugees and asylum seekers, offering comprehensive medical coverage for refugees for an eight month period upon arrival. In this paper I conduct a comparative analysis between Canada and the United States in the area of refugee health care policies. The analysis concludes Canada is moving closer to emulating the existing refugee health policy in the United States. In addition, in this paper I argue that the ways legitimate refugees have been framed in the United States have also influenced recent shifts in the way Canada has narrowed the scope of who qualifies as a legitimate refugee and what state services these persons are eligible to receive.

List of Abbreviations

CIC	Citizenship and Immigration Canada
CMA	Cash and Medical Assistance Program
DCO	Designated Country of Origin
IFHP	Interim Federal Health Program
IRB	Immigration and Refugee Board of Canada
RMA	Refugee Medical Assistance
UNHCR	United Nations High Commissioner for Refugees

I. Introduction

The United Nations High Commissioner for Refugees (UNHCR) estimates that in 2012 the number of forcibly displaced people exceeded 42.5 million worldwide, including refugees and internally displaced persons (UNHCR Global Trends Study, 2012). Of these displaced persons, Canada accepts approximately 10 000 refugees each year through government assisted and privately sponsored refugee programs, as well as another 10 000 through the In-Canada Asylum Program (Government of Canada, Citizenship and Immigration Canada, 2013). While, the Government of Canada states its commitment to increasing refugee claims and enhance refugee support programs, the same government enacted a series of changes to the Interim Federal Health Program (IFHP). The reform limits medical insurance coverage for certain classes of refugees making it difficult for these groups to gain access to appropriate health care services (Government of Canada, Citizenship and Immigration Canada, 2012).

Restructuring of the IFHP by Citizenship and Immigration Canada (CIC) represents a shift from a menu of medical services more comprehensive than the average Canadian is eligible to receive to one less comprehensive than the average Canadian receives. The cuts have been met with objections from leading health associations, including Canadian Doctors for Refugee Care (Canadian Doctors for Refugee Care, 2014), refugee advocacy groups, such as the Canadian Association of Refugee Lawyers (Canadian Association of Refugee Lawyers, 2014) and provincial governments who claim the health insurance cuts bring into question Canada's moral obligation to provide health care to one of Canada's most vulnerable groups.

In the United States, refugee health care is provided by the Refugee Medical Assistance (RMA) program for a period of eight months, after which the refugees must acquire private health insurance (usually through employment) or in some cases the refugee may qualify for Medicare or Medicaid. The *Affordable Care Act* introduced in 2010 expands refugee health care insurance options to that equal to low income groups by enabling refugees to become eligible for Medicare or Medicaid and provides more affordable options for private health insurance.

According to the 1951 United Nations Refugee Convention refugees should be granted access to the health services equivalent to that of the host population. Based on this requirement, Canada and the United States have both fulfilled their international obligation on health care provisions, but this has not always been the case for Canada which offered services beyond this requirement. Therefore, an important question is what accounts for the recent changes to refugee policy? And does American refugee policy have an influence on Canadian policy objectives when it comes to framing refugee policy?

The Government of Canada justifies the health care cuts for refugees on the basis of “fairness” to the Canadian public (CICS News, 2012), cost effectiveness and as a deterrent for refugees coming to Canada for the sole purpose of using public health care services (Canadian Doctors for Refugee Care, 2014). This position represents a new direction in Canadian refugee policy but how does this position align with other developed countries in terms of refugee policies? In this research paper I will compare Canadian and American refugee health care policies in order to identify the reasons why Canada has moved toward a less comprehensive policy on health services for refugees. This paper seeks to determine if Canada has engaged in

policy learning by adopting similar policy frames in developing new definitions of legitimate refugees. In searching for the “why” this paper examines the political and economic arguments put forward by Canadian and American politicians and other government officials.

The paper will begin with an overview of the methodology and then move to outline some key aspects of comparative politics, including the concept of policy learning and issue framing. Next, this paper will examine American refugee health policy followed by an examination of the recent changes to Canadian refugee health policy. The final section will include an analysis of policy framing in order to identify if Canada has adopted similar policy framing when it comes to redefining the definition of refugees. This paper is interested in finding evidence of policy learning between Canada and the United States when it comes to refugee health care policies and will do so by examining the political discourse in how refugees are framed, what is a legitimate and illegitimate refugee and what government services refugees and asylum seekers are entitled to receive.

II. Methods

In developing a comparative analysis of refugee health care policy in Canada and the United States, this paper will examine primary and secondary resources. The first section draws primarily on academic sources in defining concepts of comparative politics. The following sections will provide an overview of policy changes to refugee health care in the United States and Canada and will rely on academic sources, as well as newspaper articles, editorial pieces, refugee support group reports and government publications from various government

departments including, refugee, immigration and health. This paper is also interested in finding evidence of shifts in policy framing by examining government documents, media representations on refugee issues and public opinion polls that illustrate the changing perspective in refugee health policy.

III. Comparative Politics Framework

Canadian and American refugee health policy analysis will be conducted within a comparative politics framework. As a subdiscipline of political science, comparative politics is distinct from political theory and international relations as a result of its focus on the comparative method. According to Arend Lijphart (1971) the comparative method is among one of the basic methods including, experimental, statistical and case study, whereby comparisons between countries can highlight similarities and differences. Comparative politics can be used to answer political questions within a country, state or political system (Lim, 2010). The comparative method can also be used to gauge the effectiveness and success of public policy, such as questions in the areas of health care, education, trade, and immigration policies.

Distinct from the experimental, statistical and case study methods, the comparative method offers a framework to assess a limited number of cases (Fabbrini and Molutsi, 2011). The comparative method is also beneficial for generating an in-depth analysis of each case, as well as proving effective for hypothesis testing. However, some of the weaknesses of the comparative method are the result of the limited number of cases which can be evaluated at one time. As a result hypothesis testing can have limited application given the requirements for case

selection (Fabbrini and Molutsi, 2011). In addition, evaluating a number of variables within few cases may result in problems with identifying causation and correlation. According to Lijphart (1971) the weaknesses of the comparative method can be minimized by increasing the number of cases or decreasing the number of variables. In each scenario, case selection is fundamental for the integrity of the analysis.

This paper applies a qualitative analysis in examining refugee health policy in Canada and the United States, enabling us to examine factors beyond the scope of quantifiable data, such as examining how refugees are framed in Canada and the United States and any changes in political discourse over time. Qualitative analysis within comparative politics allows us to contextualize our case studies in order to identify cross-case relationships, (Ragin and Rubinson, 2011) especially as we examine refugee health policy, an area which has received little academic attention until now.

Case Selection

Cases in comparative politics are selected through the basis of most similar or opposite cases (Lim, 2010). The Canadian and American cases are comparable for their similar refugee resettlement policies, including refugee health care policies. Both countries share a similar history of open refugee policies in the post war era. Following the end of Second World War Canada resettled nearly a quarter of a million refugees by 1962, mainly displaced persons from Western Europe, former Baltic States, as well as, Palestine-Arab refugees resulting from the Israel-Palestine conflict (Canadian Council on Refugees, 2009; Immigration and Citizenship

Canada, 2012). In the 1970s Canada increased its humanitarian role, taking a leading role in refugee resettlement during the conflicts in Uganda, Chile, Vietnam, Cambodia and Iran (Government of Canada, 2012). Canada ratified the *United Nations Convention on the Status of Refugees* in 1969. In the decades that followed Canada continued to increase its refugee intake to include refugees from Latin America, Asia, Africa and the Middle East.

Similarly, American refugee policy was the result of an influx of a similar mix of refugees and the United States government adopted a number of pieces of legislation designed to address the needs of refugees and internally displaced persons. These acts included the *Displaced Persons Act* of 1948 and the *Refugee Act* of 1980 (Refugee Council USA, 2014). In addition, the United States signed the 1967 *Protocol to the United Nations Convention on the Status of Refugees*.

When it comes to health care policies, Canadian and American systems differ greatly and it is difficult to draw comparisons. But in the specific case of refugee health care the two countries are quite similar. In both Canada and the United States refugees are eligible for health services funded by the federal government, if only for a limited period of time. The Interim Federal Health Program established in 1957 in Canada and the Refugee Medical Assistance Program established in the United States as part of the *Refugee Act* of 1980 are federal temporary programs responsible for medical services to refugees and asylum seekers. Once refugee and asylum seekers complete residency terms medical services fall under the jurisdiction of provinces and states.

Defining Policy Learning and Policy Framing in Comparative Politics

Policy learning in comparative politics can provide insight into why and how governments adopt new policies. According to Paul Cairney (2013) “policy learning describes the use knowledge to inform policy decisions.” Policy learning begins when countries identify a policy problem or concern and examine international cases in order adopt, learn or emulate policies (Dolowitz and Marsh, 2000). Policy learning can occur as policy actors transfer ideas, attitudes and concepts. Not all cases of policy learning may result in the replication of exact policies.

This paper will assess policy frames in refugee health care policy in Canada and the United States. Robert Entman (1993) emphasizes the importance of framing in influencing thinking and policy outcomes. For Entman (1993, pp. 52) framing in about *selection* and *salience* and defines framing as:

“...to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, casual interpretation, moral evaluation, and/or treatment recommendation for the item prescribed.”

Framing enables us to define a problem, assess and identify causes in order to prescribe solutions. In the policy context frames are important in shaping the issue, in order to align with policy responses. When examining Canadian and American refugee health care policies an assessment of policy frames will identify the prevailing frames for refugees and whether these frames have changed since 2012.

IV. Refugee Health Care in the United States

Historically the United States has been an international leader in refugee resettlement, opening its doors to over 3 million refugees since 1975 (US Department of Health & Human Services, 2014). Proportionally the United States has taken on a greater number of refugees and asylum seekers than any other country in the world. In addition, the United States offers federal programs, such as the Refugee Medical Assistance (RMA) program and the Cash and Medical Assistance (CMA) program, social services and income support, including the Refugee Cash Assistance Program and preventative health services, such as Medical Screening Examinations for refugees upon arrival. When it comes to medical insurance refugees and asylum seekers qualify for a temporary federal program, after this period ends these persons may qualify for state programs equivalent to that offered to low-income groups.

When it comes to refugee health policy, American and Canadian systems are comparable. Most Americans have private health insurance plans or participate in public programs such as, Medicaid or Medicare, while as many as 45.2 million Americans have no medical insurance of any kind (Centers for Disease Control and Prevention, 2014). Low income families and persons with disabilities may qualify for Medicaid and persons over the age of 65 or persons with certain disabilities may qualify for Medicare (US Department of Health and Human Services, 2014). While national public medical insurance programs remain a controversial topic in America, there has been little reform for refugee and asylum seeker health care policies since the introduction of the federally funded program introduced in 1980.

The Refugee Control Act of 1980 and later the *Immigration Reform and Control Act* of 1986 defines a refugee as:

Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person habitually resided, and who is unable or unwilling to avail himself or herself of the protection of that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. (Refugee Council USA, 2014).

At the beginning of every fiscal year a refugee ceiling on the maximum number of refugees is set by the President after consultation from Congress. In 2013 the refugee ceiling was set at 70 000 (Bruno, 2014). *The Refugee Control Act* in 1980 established setting refugee ceilings as a federal decision, thus requiring federal financial responsibility and support. According to a report by the Congressional Research Service (2014) since refugees enter on a humanitarian basis, they differ from other immigrants with family and employment requirements and do not need to demonstrate financial self-sufficiency.

Eligible refugees qualify for the Cash and Medical Assistance (CMA) and Refugee Medical Assistance (RMA), part of the federal Division of Refugee Assistance which is delivered by state government programs. The CMA and RMA programs reimburses each state government 100% for the services provided to refugees, in addition to administrative costs accrued in the delivery of these services (US Department of Health and Human Services, 2014). The CMA and RMA programs are eight month temporary programs after which refugees can apply for Medicaid or the Children's Health Insurance Program or acquire medical insurance through employment. Under the CMA and RMA Programs refugees are entitled to the same

coverage as Medicaid depending on the state for which the refugee resides. Many refugees also find themselves without any medical insurance at all.

According to the *Proposed Refugee Admissions for Fiscal Year 2014: Report to the Congress* released by the United States Department of State, Department of Homeland Security and Department of Health and Human Services (2014) medical assistance for refugees is necessary for effective refugee resettlement in order for refugees to achieve economic self-sufficiency and integration in a timely manner upon arrival. Refugee Medical Assistance is equivalent to that of state government welfare programs available to low-income families as refugees are recognized as a vulnerable sector of the population requiring state support.

The introduction of the *Affordable Care Act* in 2010 expanded eligibility requirements for Medicaid for refugees, asylees, Cuban-Haitian entrants, Iraqi and Afghan Special Immigrant visa holders and certain victims of human trafficking. While on the surface the 2010 Act expanded refugee medical services eligibility, the changes served to put certain refugees and asylees on the same level with the medical health insurance the state extends to low-income families in America. According to the UN Convention on Refugees the state is required to provide refugees the same medical services as offered to the general population. Thus, the changes to refugee health coverage under the *Affordable Care Act* ensure the United States has met its international responsibility to provide health care options given to the general non-refugee population.

However, even with the expansion of medical insurance coverage for refugees under the *Affordable Care Act* many refugees find accessing affordable healthcare challenging. For

example, once RMA expires after eight months many working class refugees may be ineligible to receive Medicaid or Medicare due to their income but find themselves unable to afford private medical insurance that covers required medical expenses (Beras, 2014). Furthermore, according to refugee health advocates the current system is insufficient as some medical conditions may take months to identify or begin to show symptoms after eight months when refugees may no longer have medical insurance coverage (Beras, 2014).

Refugee Status and Medical Insurance Eligibility

A major difference between the American and Canadian system prior to the changes in 2012 by the Government of Canada is defining which refugees as eligible for public health insurance coverage. Similar to Canada, the majority of refugees entering the United States fall under the category of resettled refugees. The United States accepts a limited number of refugees each year. Only those refugees recommended by the United Nations High Commissioner for Refugees (UNHCR) or a United States Embassy for resettlement are granted an interview. Other groups may qualify for refugee resettlement if they have family members in the United States, or for humanitarian reasons under special circumstances. Once granted refugee status these persons qualify for medical assistance programs.

However, asylum seekers take a different pathway to residency and are entitled to different social benefits. Asylum seekers begin the application process while in the United States and may only qualify for state medical services once a positive decision has been made on their claim. Prior to receiving a positive decision asylum seekers are ineligible for work

permits and are not entitled to any government social services (Empire Justice Center, 2008). Exceptions to work permits for asylum seekers is made once 150 days have passed when no decision on the application has been made.

Human Rights Watch released a report in 2013 condemning the restrictions placed on asylum seekers in America compared to other vulnerable migrant groups, such as humanitarian refugees and trafficked persons. The United States is one of 44 developed countries with individualized asylum claims (Human Rights Watch, 2013). Since asylum claimants are not eligible for federal medical services (until a positive decision is made) and are not entitled to work, acquiring private medical insurance through employment is almost impossible, placing asylum seekers in a precarious position.

Distinguishing Between Refugees, Asylum Seekers and Undocumented Immigrants

In addition to distinguishing between refugees and asylum seekers, undocumented immigrants also compose a large group in America which complicate the perception of legitimate refugees and asylum seekers. Estimates place the number of undocumented immigrants in America at approximately 11.7 million (New York Times, 2014), the majority of these immigrants coming from Mexico and other Central American countries (mostly El Salvador, Honduras and Guatemala) (Pew Research Center, 2013).

Undocumented immigrants are presented in the media in a highly politicised framework. Using terms such as, illegal aliens, illegal immigrants, or simply illegals present this groups as criminals with limited rights (Vargas, 2012). The Federation for American

Immigration Reform (2013) is among several organizations raising concerns over undocumented migrants stealing American jobs and pushing for measures to decrease undocumented workers in the United States. Despite laws, such as the 1986 *Immigration Reform and Control Act* meant to discourage American employers from hiring undocumented migrants, hiring undocumented immigrants continues generating public pressures on governments to crack down on deportation and border security as a means of controlling migration flows.

While undocumented immigrants present a separate and challenging immigration problem in the United States, the perception of “illegals” entering the country also present challenges for refugees and asylum seekers as “legitimate” or official designated groups which are entitled to state support. For example, perception of refugees “as a strain on the tax payer” (Redmond, 2014) has already promoted some states and cities, including Georgia and Springfield, Massachusetts to limit the number of refugees being resettled into their communities (Fox News, 2014). Distinguishing between asylum seekers and undocumented migrants is especially problematic as many undocumented migrants are eligible for asylum status fleeing from gang-related violence and poverty from Latin America.

Reducing Refugee Intake Following 9/11

While refugee health policy saw little change since 1980, refugee policy and intake flows reflected changing government attitudes on border security. Immediately following the 9/11 terrorist attacks the Bush Administration enacted a series of measures to tighten border

security, including limiting the number of refugees admitted in the following years. In 2002 refugee inflows reached an all-time low, when only 26,773 refugees were admitted (Department of Homeland Security, 2013). Since 2002 refugee intake has steadily increased reaching 74 000 in 2009 before declining in 2012 to 58 000 refugees (See Table 3: Refugee Arrivals: Fiscal Year 1980 to 2012 in Appendix).

The reduction of refugee inflows is a result of an increase in clearance processes, including the introduction of the inter-agency check (IAC) in 2011 (Kerwin, 2011). The introduction of additional clearance processes resulted in the delay of approved refugee claims. According to Donald Kerwin (2011) of the Center for Migration Studies of Pennsylvania State University School of International Affairs approximately 70 000 approved refugees are awaiting clearance to enter the United States.

Furthermore, increased border security has added additional barriers for refugees hoping to make asylum claims within the United States. The *US Patriot Act* in 2001 and the *Real ID Act* of 2005 instituted a series of measures making it more difficult for refugees to be granted refugee or asylum status (Kerwin, 2011). Under the new legislation refugee claims on the basis of terrorist activity were limited, placing a greater onus on refugee claimants to prove their case. The border security frame has been used to guide refugee policy through enhancing screening processes and limiting the definition of legitimate asylum claims.

V. Refugee Health Care in Canada

Although health care falls under provincial jurisdiction, the federal government is responsible for providing health care coverage for refugees, Aboriginal Peoples, federal inmates and military personnel (Maioni, 2012). The creation of the Interim Federal Health Program in 1957 by the Order-in-Council granted refugees access to health care coverage, primarily for humanitarian reasons (Canadian Healthcare Association, 2012). Under this Program, refugees were granted coverage for essential medical services, emergency services, as well as, pharmacy, optical and dental services (Canadian Healthcare Association, 2012). While, pharmacy, optical and dental services go beyond provincial health coverage offered to most Canadians, the IFHP included these services deeming them necessary for the successful integration of refugees into Canadian society.

Since 1995, the IFHP has been administered by Citizenship and Immigration Canada (CIC), contracting Medavie Blue Cross as the primary insurance program provider (CIC, 2012). The IFHP covers refugees, asylum seekers and victims of human trafficking.

Refugee Status and IFHP Eligibility

Changes to the IFHP were introduced with the 2012 Budget, whereby the 1957 Order-in-Council was repealed and replaced with the Order Respecting the Interim Federal Health Program (Government of Canada, Canadian Gazette, 2012). Under the new federal legislation, which came into effect June 30, 2012, the medical services for refugees and asylum seekers were reformed based on refugee status (See Appendix Table 1). The IFHP would limit the

medical services offered to refugees and protected persons to be closer to the range of provincial medical services offered to the average Canadian.

Similar to the United States, the new system distinguishes eligibility for health care coverage for refugees based on their application status. Under the new system, the category of refugee status is paramount in order for health care providers to determine medical health coverage eligibility. The categorization of health care coverage suggests the Government of Canada has prioritized certain groups of refugees over others.

The IFHP is now divided into several categories of medical insurance coverage based on refugee status including: Expanded Health-Care Coverage and Immigration Medical Examinations, Health-Care Coverage and Immigration Medical Examinations, Public Health or Public Safety Health-Care Coverage and Immigration Medical Examinations and Coverage for Detainees and Immigration Medical Examinations (See Table 1 in Appendix). Changes to the IFHP greatly affected certain groups of refugees, creating significant barriers for many refugee groups in accessing medical services in Canada.

Refugees qualifying for Expanded Health Care Coverage were the least affected by the changes, as benefits remained relatively untouched by the reform. Government-assisted refugees, Victims of Human Trafficking and persons whom the Minister exercises discretion qualify Expanded Health-Care Coverage (Government of Canada, Citizenship and Immigration Canada, 2012). Expanded Health-Care coverage includes, essential and emergency medical services, as well as, supplementary coverage encompassing audiology care, emergency dental, home and long-term care, midwife services, occupational therapy, physiotherapy, post-arrival

health assessments, psychotherapy, vision care and immunization and medical supplies (CIC, 2012); in short, medical services equal to the old system.

However, refugees eligible for Health Care Coverage and Immigrant Medical Examinations experienced a reduction in medical services covered by the IFHP. Groups who fall under this category include Protected Persons, (persons who receive a positive decision on their refugee claim from the Immigration and Refugee Board of Canada, IRB), persons who receive a positive decision on their pre-removal risk assessment, Privately-Sponsored Refugees and refugee claimants awaiting decisions who are not from a designated country of origin (DCO). Health Care Coverage includes essential medical services, such as hospital services (doctor or nurse visits), laboratory, diagnostic and ambulance services with limitations, as well as, medication and vaccines only under the condition that they are necessary for the prevention and treatment of a disease posing a health and safety risk to the Canadian public, (public health risks, such as human immunodeficiency virus and tuberculosis). The coverage does not include dental, vision and prescription drug coverage.

Public Health or Public Safety Health-Care Coverage and Immigration Medical Examinations is even more limited in medical coverage. Refugees who fall into this category include, refugee claimants from a DCO, refugee claimants whose application for refugee status has been suspended or abandoned and rejected refugee claimants. Under this plan the only medical services covered are medications and vaccines deemed necessary for the protection of

public health, such as human immunodeficiency virus and tuberculosis and does not include essential medical services.

Finally, Coverage for Detainees and Immigration Medical Examinations apply to persons who are detained under the *Immigration and Refugee Protection Act* (IRPA). Under this plan only services and products medical professionals deem urgent and essential are covered (Medavie Blue Cross, 2012). The next section examines the different policy frames used by the Government in justifying the changes to refugee health care coverage.

The Fairness Frame and Refugee Health Care

The official position of Citizenship and Immigration Canada was that under the old system, Canada was placing an unfair burden on Canadian taxpayers by offering refugees and protected person's medical services beyond the basket of medical services covered by provincial and territorial medical coverage. On April 25, 2012 former Citizenship and Immigration

Minister Kenney stated:

Our Government's objective is to bring about transformational changes to our immigration system so that it meets Canada's economic needs. Canadians are a very generous people and Canada has a generous immigration system, however, we do not want to ask Canadians to pay for benefits for protected persons and refugee claimants that are more generous than what they are entitled to themselves (Government of Canada, News Release, 2012).

Rick Dykstra, Parliamentary Secretary to the Minister of Citizenship and Immigration also supported the changes under Bill C-31 stating:

It again shows that Canadians have always been known to be fair and compassionate. Our country has a long and proud humanitarian tradition. This bill only strengthens that

tradition all the more. However, it is safe to say that our system, and it is no secret, is also open to abuse. We see that abuse on a daily basis... Canadians have told us loud and clear again and again that they want a stop put to the abuse which exists within our immigration system. (Open Parliament, 2013).

Both the Minister and Parliamentary Secretary to the Minister of CIC make the case for the amendments to the IFHP as a necessary measure to combat past abuses of the system by unfounded refugee claims. The issue has been framed as one based on “fairness” by eliminating services offered to certain groups, as well as one of reform in order to deter any future unfounded refugee claims.

The Deterrence Frame: Restructuring Canada’s Asylum System

The changes to refugee health care are aligned with broader reform objections instituted by the Government of Canada to restructure Canada’s asylum system. In attempts to address concerns with prolonged delays in processing claims for asylum seekers, the *Protecting Canada’s Immigration System Act* was passed and came into effect December 15, 2012. The Act stipulates that under the new asylum system, Designated Countries of Origin will be defined as those “democratic countries that offer state protection, have active human rights and civil society organizations, and do not normally produce refugees” (Government of Canada, Citizenship and Immigration Canada, News Release, 2013). DCO include countries such as the United Kingdom, the United States, France, Germany, Finland, Sweden, Australia and New Zealand among other industrialized countries with strong human rights traditions. However, DCO also include countries with controversial human rights track records, including Hungary,

the Czech Republic and Mexico (CIC, 2013). As a result, claimants from a DCO are ineligible for making new asylum claims. The new system has proved successful in reducing asylum claims from DCO by nearly 91% (CIC, 2013).

Similar to justifications for the IFHP reform, the creation of DCO lists were created in order to address concerns with efficiency in processing asylum claims. Changes under *Bill C-31* to include DCO were deemed necessary in order to combat the gross abuse of the Canadian system by those looking to take advantage of the Canadian immigration system through “bogus refugee claims” according to the Government of Canada. In order to deter such unfounded refugee claimants CIC instituted changes to narrowly define legitimate refugees and limit federal services offered to refugees and protected persons. This policy reform also included making DCO claimants ineligible for work permits until their claim has been approved by the IRB or 180 days have passed. Along with the changes to the IFHP, the reform to refugee policy has proved to be effective in reducing claims from DCO.

For example, Canada listed Hungary on the DCO list, deeming it safe in order to reduce the number of Roma asylum seekers originated from Hungary. Since 2010 Hungary has been the largest source of asylum claims for Canada; these claims are often withdrawn, abandoned or determined to be unfounded by the IRB (Keung, 2013). The Government has also taken additional steps in deterring Roma asylum seekers from Hungary by embarking in a billboard campaign in the city of Miskolc, Hungary advertising Canada’s accelerated deportation process for failed asylum seekers. Press secretary for former Citizenship and Immigration Minister Jason Kenney, Alexis Pavelich released a statement (Levy-Ajzenkopf, 2013) saying “Canadians

have no tolerance for those who abuse our system and seek to take unfair advantage of our country at great expense to taxpayers.” Despite criticisms from Roma advocates claiming that campaigns such as these have intensified racism against the Roma in Hungary, the Government strongly supports the measures as part of necessary immigration reform.

However, the changes to refugee health policy have generated a number of concerns and sparked opposition from refugee advocacy groups and medical associations. The next section examines the concerns raised by these groups.

Opponents of the IFHP Cuts

One of the major concerns raised by opponents to the changes to the IFHP is that the reform puts an already vulnerable group into an even greater precarious position. According to the Canadian Council for Refugees (2012) while the “fairness” argument may hold in principle, this perspective ignores the reality of refugee medical needs. In addition, studies indicate (Barrios et al, 2011; Raza et al 2012) that refugees have increased health risk as a result pre-migration exposure to war, conflict and emergency evacuation. Refugees may also be at a higher risk for infectious diseases and mental health concerns and be exposed to poor health conditions in refugee camps, such as lack of proper sanitation, nutrition and medical services.

According to a study on the effects of IFHP cuts conducted by the Wellesley Institute (Barnes, 2013) many refugees have been restricted in accessing primary and preventative care. Refugees under Health Care Coverage with chronic conditions who require medications, such as inhalers or insulin no longer have prescription drug coverage. For example, under the new

system, many refugees medication not considered necessary for the protection of public health is not covered, including cancer treatment and symptom management, such as chemotherapy and anti-nausea medication.

The cuts have also had a significant impact on women and children who fall into these categories. Women who fall under certain refugee categories may also be denied pre-natal care for pregnant mothers and psychotherapy services for victims of post-traumatic stress from physical and sexual violence (Canadian Council for Refugees, 2012). Ironically, many of these medical services are included in Canadian development programs in refugee camps overseas, but are no longer part of the medical services offered to certain refugees and protected persons within Canada (Canadian Council for Refugees, 2012).

The gap in medical insurance for certain groups of refugees and asylum claimants have prompted six provinces, Alberta, Manitoba, Saskatchewan, Nova Scotia, Quebec and Ontario to reinstate essential and urgent care for certain refugee and asylum claimants who were affected by the federal changes to the IFHP (The Canadian Press, 2014). Ontario Health Minister Deb Matthews announced that the temporary program for refugees will cover hospital, primary, specialist, laboratory and diagnostic services starting January 1, 2014 (Keung, 2013). The provincial program was a direct response to the increase use of emergency medical visits refugees and asylum claimants were forced to use as a result of the changes.

However, earlier this year Citizenship and Immigration Minister Chris Alexander publically condemned the Ontario government's decision to reinstate health care coverage for refugees directly affected by the IFHP reform. Minister Alexander expressed his disappointment

with the province by stating, “Simply arriving on our shores and claiming hardships isn’t good enough. This isn’t a self-selection bonanza, or a social program buffet” (Mas, 2014). The Minister’s statement further supports the Government’s claim that the majority of refugees are “bogus claims” from foreigners seeking to take advantage of the Canadian system. However, the Government has failed to address concerns with restrictions places on legitimate refugee claimants, such as those awaiting decisions, or privately sponsored refugees who have found themselves with limited means of accessing affordable health care.

In addition, the Canadian Doctors for Refugee Care, the Canadian Association of Refugee Lawyers, Justice for Children and Youth, Daniel Garcia Rodriguez and Hanif Ayubi launched a legal challenge against the Government of Canada at the Federal Court of Canada claiming that the cuts made to the IFHP are invalid (Loriggo, 2013). The claimants argued that since the changes were done through royal prerogative, without the consultation of stakeholders, such as provinces, doctors, medical association and lawyers, health and immigration is governed by law, the current changes to the IFHP are unlawful and should be reversed.

The stories of Daniel Garcia Rodriguez and Hanif Ayubi are only two examples of the hardships many refugees are facing as a result to the cuts to refugee health insurance. Mr. Garcia Rodriguez and his wife both filed refugee claims in Canada on the basis of persecution by paramilitaries in Colombia; however, only his wife’s claim was approved. Mr. Garcia Rodriguez subsequently lost his health care coverage while at the same time facing severe vision loss requiring immediate surgery. Unable to pay for the surgery without medical coverage, Mr. Garcia Rodriguez faced the threat of permanent vision loss from chronic retinal detachment.

However, a Toronto surgeon proceeded with the surgery, with his private practice and the hospital absorbing most of the cost (Keung, 2012). Mr. Garcia and his wife have both been employed since arriving in Canada and have a Canadian-born daughter together, challenging the Government idea of bogus refugees claimants seeking to abuse the Canadian system.

Similarly, Mr. Hanif Ayubi's health was also compromised when he was no longer covered by the IFHP. Mr. Hanif Ayubi's refugee claim was denied but he could not be sent back to Afghanistan as there is a moratorium on removals to the country. With no medical insurance coverage, Mr. Hanif Ayubi was unable to afford insulin to treat his Type 1 diabetes despite holding a work permit, being employed and paying taxes in Canada. Mr. Hanif Ayubi's vital medication was subsequently covered by an Ottawa community medical clinic in the absence of government medical insurance (Jones, 2013).

On July 4, 2014 the Federal Court ruled in favor of the claimants, stating that the Government's treatment of refugees through the cuts to the IFHP were "cruel and unusual" placing those affected by the changes in a highly vulnerable position (Payton, 2014). Justice Anne Mactavish's decision responded to the concerns raised by medical associations and refugee advocacy groups on the rights of refugees and refugee claimants in Canada. In the Court Decision Judge Mactavish (2014, pp. 7-8) states:

"With the 2012 changes to the Interim Federal Health Program, the executive branch of the Canadian government has intentionally set out to make the lives of these disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here."

The Federal Court responded to the claims made by the Government that the IFHP changes only affected “bogus refugee claims” (CBC News, 2014) and in fact, the cuts have severely affected legitimate refugee claimants, including children brought to Canada by their parents. Judge Mactavish’s ruling also raises ethical issues with the Government’s decision to use reduction of health care coverage for certain refugee groups as a deterrent for future refugee claims.

The fairness framing is once again echoed by Citizenship and Immigration Minister Chris Alexander’s response to the recent Federal Court ruling on the IFHP. Minister Alexander affirmed the Government’s position to appeal the court decision and stand firm behind the changes by stating that the Government will “vigorously defend the interest of Canadian taxpayers” (Playton, 2014). In response to questions concerning the verdict, CIC Minister Alexander framed the issue as one of fairness, stating the past system overextended its generosity to failed refugee claimants seeking to take advantage of Canada’s open refugee system.

VI. Framing Legitimate and Illegitimate Refugees in the United States and Canada

The changes to the IFHP by the federal government in 2012 generated strong opposition from medical professionals, refugee groups and human rights organization representing the interests of refugees and asylum seekers in Canada. Opponents objected to the classification of certain groups of refugees and asylum seekers as more deserving of medical assistance than others, challenging the Government’s commitment to refugee resettlement by creating a multi-tier system for refugees. This section tries to answer the question: what conclusions can we

draw from comparing American and Canadian policy frames on refugee health policies? And why did the Government of Canada reform refugee health care at this time?

Comparing Canadian and American Refugee Health Policies

Comparing Canadian and American refugee policies may help explain why Canada is currently shifting its policies for refugees and asylum seekers. Canada and the United States share similar refugee policies, with both countries acting as international destinations for refugee resettlement. According to the Migration Integration and Policy Index (2010) which examines integration programs for newcomers, including refugees and asylum seekers, for thirty one countries Canada and the United States share similar scores, with Canada receiving a slightly higher score than the United States (see Figure 1 in Appendix). Distinct from other European countries Canadian and American refugee policies focus on refugee resettlement with the UNHCR rather than in-country asylum claims.

For example, European countries have experienced an increase in asylum claims over the past ten years, with the greatest asylum intake concentrated in the five Nordic states, including Sweden, Norway, Iceland, Finland and Denmark (UNHCR, 2012). In 2011 Sweden received 49 900 asylum claims, resulting in a 30% increase in asylum claims over the year. While the United States receives a higher number of asylum claims, when we examine asylum claims based on the national population the United States does not rank in the top ten asylum destination countries. Countries including, Malta, Sweden, Liechtenstein, Norway, Cyprus and Switzerland have higher numbers of asylum seekers per one thousand inhabitants (UNHCR,

2012). Moreover, Canada has actually experienced a decrease in asylum claims since 2011 despite steady increases in asylum claims among other industrialized countries according to the 2012 UNHCR Global Trends Report.

This is an important distinction when it comes to refugee policy as resettlement enables countries to monitor and document those entering the country. Refugee claims made through UNHCR refugee camps ensures Canadian immigration officials have records of this incoming group of refugees. In contrast, asylum claims are made once already claimants are within Canadian borders; as a result monitoring asylum seekers is a more difficult process. The American case exemplifies important features when drawing parallels with the Canadian case when it comes to defining who is a legitimate refugee.

Canada and the United State Before and After 2012

Canada has for many years been a leader in refugee resettlement, working with the UNHCR to resettle thousands of refugees, providing financial, medical and social services to newcomers. The establishment of the IFHP as early as 1957, nine years before the Medical Care Act extended universal, provincial health care coverage across Canada demonstrated Canada's commitment to refugee integration. The IFHP covered essential services, as well as prescription, dental and vision coverage for refugees until refugees qualified for provincial health coverage. As a result, refugees and asylum seekers shared continual medical insurance coverage by either federal or provincial programs. This system went beyond international

standards by extending refugees and asylum seekers medical programs than that offered to the general population.

Similarly, the United States offers a temporary RMA program for refugees for a period of eight months. However, an important distinction is that this federal program is equivalent to that of Medicaid or Medicare offered to low-income families and seniors and does not offer coverage beyond that offered to these groups. Prior to the IFHP Canada offered refugees and asylum seekers a slightly more inclusive package of medical insurance than the United States.

However, with the introduction of the health care cuts for refugees in Canada in 2012 refugees and asylum seekers no longer share the security of access to public medical insurance. Only government-sponsored refugees remained unaffected by the changes, placing other categories of refugees without access to certain medical service coverage, such as dental, prescription drug plans and psychological therapy treatment. Asylum seekers are particularly vulnerable given the strict requirements needed in order to make a successful asylum claims within Canada.

After 2012 Canadian and American refugee health care policies share greater similarities. The cutbacks to the IFHP eliminated medical insurance coverage for some refugees emulate a major feature of the American system, which is granting public health insurance coverage to only those who have been granted a positive decision on their refugee claim. The American RMA program does not have a medical insurance plan for refugees in the process of an asylum claim or failed refugee claimants. When examining Canadian fairness and deterrent

frames for refugee health care it is clear that the government has narrowed the definition of who is a legitimate and illegitimate refugee.

Framing Legitimate Refugees and Illegitimate Refugees

Comparing American and Canadian refugee health policies can help explain how the Canadian government can justify reducing refugee health services by narrowing the scope of legitimate refugee in Canada. An important similarity identified among the two systems is prioritizing UNHCR refugees over asylum seekers by enacting policies which recognize certain classes of refugees as eligible for state services, over others.

In America, framing refugee policies within the broader frame of border security has been a dominant frame not present to the same degree as in Canada. Due to America's serious problem with undocumented immigrants the government is under pressure to increase border security in order to reduce the flow of illegal migrants. Since the Bush Administration in 2001 border security has been a dominant frame in refugee and immigration policy on a broader level resulting in an increase in policies to screen incoming refugees. Creating procedural mechanisms to act as gatekeepers has been one way the United States has kept refugee flows down from previous years, especially refugees hoping to make asylum claims within the United States. There is a greater onus on asylum claimants to demonstrate grounds for asylee status.

In the United States the illegitimacy of asylum seekers is highlighted within anti-immigration frames, particularly strong among Republican political discourse. Since the 2008 recession immigration levels in the United States have dropped while immigration has become increasingly politicized. According to recent poll by Gallup (2014) 1 in 6 Americans identifies

immigration as one of the most important problems facing the country. The poll also found that Republicans were significantly more concerned over illegal immigration than Democrats.

Recently, the issue of undocumented children from Central America crossing the border into the United States has raised debates concerning humanitarian refugee policy versus border security. This year an estimated 57 000 unaccompanied children, mainly from Honduras, Guatemala and El Salvador crossed the American border illegally; almost double the number from the previous year (Restrepo and Garcia 2014). The United States is not alone as neighbouring countries in Central America have also experienced an influx in asylum seekers from these countries due to regional gang-related violence, poverty and homicide rates (UNHCR, 2014).

Polls suggest that Republicans are less likely to support treating these children as asylum seekers than Democrats (The Guardian, 2014). Republicans opposing the influx of Central American children as asylum seekers frame the issue as one of cost effectiveness and deterrence to stop illegal migration. Some Republicans argue that the children will place a burden on taxpayers, through refugee resettlement programs, like the RMA program. Others argue that by not deporting these children, America may be encouraging rather than deterring illegal migration flows (Nakamura and Payne, 2014). This position falls within the border security framework, where immigration reform includes taking a tough position on asylum claims and enhancing immigration procedures.

Similarly, we are witnessing similar trends in Canada with the changes to the IFHP and the introduction of DCO lists. The changes to the IFHP had the greatest impact on asylum

seekers from DCO, who are only eligible for Public Safety Health Care Coverage (CIC, 2012). Under this program the health of the general population is prioritized over the health needs of the asylum claimants, by only providing medical services necessary for the health of the Canadian population, such as tuberculosis vaccinations.

The framing of “bogus refugees” in Canada is similar to American refugee framing of illegal migrants. For example, in February 2013 in response to the Federal Court challenge launched by Canadian Doctors for Refugee Care and the Canadian Association of Refugee Lawyers Citizenship and Immigration Minister Jason Kenney said, “...we have no legal, moral, political obligation to give taxpayer services to bogus asylum seekers, rejected claimants – people who are effectively illegal migrants,” (Jones, 2013). The term illegal migrant has generally not been part of the Canadian political discourse when it comes to immigration.

In fact, Canada has little experience with illegal immigrant flows compared to the United States. The arrival of the MV Sun Sea, Ocean Lady carrying 492 Sri Lankans in 2009 in Vancouver sparked anti-immigrant sentiments and raised concerns over illegal migrants. However, in 2010 only 3 of the 492 Sri Lankans successfully claimed refugee status in Canada, with the majority of Sri Lankans deported back to their home country. However, despite the relative small scale case of human smuggling the Conservative government used the incident to launch refugee reform policies, including the *Protecting Canada’s Immigration System Act* (Bill C-31).

In Canada, the issue of illegal immigration has not been a major concern mainly due to Canada’s geographic location and relatively consistent immigration policy welcoming around

250 000 immigrants every year (Friesen, 2012). However, changes to the refugee and asylum programs in Canada suggest the Government is increasing measures in order to restrict the inflow of certain kinds of migrants. Subsequently, changes in the asylum process in order to limit the number of asylum claims coming before the IRB indicate that Canada is already closing its borders to asylum seekers from certain regions of the world.

In comparing how legitimate refugees are framed in the United States and Canada we can draw similarities. Both countries had existing policies prioritizing resettled refugees from UNHCR camps; however, since 2001 the United States has used border security policy frames to further legitimize resettled refugees as more legitimate than asylum seekers. In Canada, since the Conservative Government's immigration reform we have witnessed a shift to delegitimize asylum seekers.

The changes to refugee health policy, within the context of a shift in refugee policy in Canada generate important questions concerning the direction Canada is taking when it comes to refugee policy in general. According to CIC (2012) Canada remains committed to being an international leader in refugee protection by first increasing the number of refugees accepted each year, and second by enhancing the services offered to these refugees. Canada has increased the number of refugees, with a 20% increase in number from 2012 to 2013 (CIC, 2013).

However, when it comes to enhancing the services to these refugees, Canada has fallen short. This may be attributed to the conflicting objectives of trying to deter unfounded refugee claims by making Canada "less desirable" in terms of services offered to "non-legitimate refugee claimants." As a result, Canada now faces an interesting policy dilemma in trying to

attract “the right” refugees; while, at the same time ensuring these refugees receive social services, including health, necessary in order to successfully integrate into Canadian society.

The changes in refugee policy in Canada, as exemplified by the changes to the IFHP, suggest that Canada may be shifting away from a system characterized by its commitment to humanitarian and moral justifications of shared social responsibility (Beiser, 2009). Canada ratified the 1951 Refugee Convention which asserts refugees should be granted access to the health services equivalent to that of the host population. Canada has traditionally also acted as an international leader in refugee policy, resulting in Canada winning the Nansen Refugee Award from the United Nations High Commissioner for Refugees for its exemplary treatment of asylum seekers in 1986 (Wallace, 2014). In addition, Canada’s commitment to universal health care and immigration policy across partisan lines suggests the Government is changing direction when it comes to the future of refugee policy. Given the international climate concerning immigration and refugee policy, particularly in Europe where some states, such as France and Switzerland are closing their borders, Canada is sending mix messages when it comes to setting its refugee policy.

Placing the IFHP Cuts within the Canadian Political Context

According to the Federal Government the changes were necessary as a result of “Bogus Asylum Seekers Racking up Health Care Costs” (CICS, 2012). Prior to 2012 there is little evidence to suggest a serious problem with unfounded refugees coming into Canada to

abuse the Canadian health care system; however, the Government acted unilaterally to reform the IFHP to address this concern.

The federal government claims the cuts to the IFHP will account for 20 million dollars in savings every year and former CIC Minister Jason Kenney called for the government to

“...scale back some of the benefits provided to refugee claimants to make sure they get essential basic care and pharmaceuticals that are necessary for public health, but that they don't get benefits not available to the average Canadian.” (Canadian Press, 2012).

The statements made by the Minister emphasize two important themes, the first highlights the political platform to cut government spending, and second putting the needs of “Canadians” first.

A major focal point of the current federal Government is the economy including promoting economic growth and balancing the national budget after the 2008 recession (Government of Canada, 2013). Within the political climate of scaling back on government expenditure the cuts to refugee health programs fall in line with the government's priorities. In addition, concerns with national health care costs across the country also allow the government to shift its priorities from refugee programs to domestic issues on healthcare.

In Canada rising health care costs is a highly contentious issue across the country. According to the Canadian Institute for Health Information (2012) Canadian health care expenditure doubled in the last decade as a result of an increase investment by federal, provincial and territorial governments after scaling back on spending during the 1990's. One of the areas of increase medical expenditures is pharmaceutical drugs, with rising pressures for a

national drug plan to aid Canadians with the cost of pharmaceutical drugs not covered by provincial medical insurance (Swedlove, 2013).

However, health care reform in Canada is a sensitive political issue politicians on the right and left of the political spectrum are weary of addressing. According to Jeffrey Simpson (2012) Medicare can be characterized as something more or less sacrosanct, stating:

“Medicare has become a national icon that politicians dare not question. In public, they can only claim undying fidelity to Medicare; in private, many of them acknowledge that it cannot continue as delivered, administered and finances, at least at current levels of taxation” (pp. 1).

Within this context, the Government’s decision to scale back on refugee health care costs was a politically strategic decision, whereby the Government can justify health care reform for “non-Canadians.”

The cuts to the IFHP also served another important political purpose in framing who are legitimate and illegitimate refugees and asylum seekers entering Canada. The cuts to the IFHP drew attention to potential abuses of the immigration system, such as those entering Canada for the sole purpose of exploiting the Canadian public health care system. Building off this concern of “not genuine refugees” (CBC News, 2014), the Government has been able to successfully narrow the definition of legitimate refugees and asylum seekers in Canada.

Future of Canada Refugee Health Care Policy

Despite efforts made by the Government to frame the issue of refugee health policy based on fairness, cost and deterrence, the media has played an important role in presenting opposing frames. Since the announcement of the changes to the IFHP major media outlets

represented the positions of opposing groups, including medical associations, refugee advocacy groups, the provinces and refugees themselves. The media played a crucial role in framing the changes in terms of humanitarian and moral responsibility, challenging the official Government position.

For example, in 2012 *The Star* ran the following headlines: “Impact of refugee health cuts: Confusion, unnecessary costs and compromised care” (Keung, 2012), “Refugees will die if health care cuts go ahead Ontario nurses say,” (Brennan, 2012) and “Doctors fight to save refugee health benefits” (Goar, 2012). The stories present a critical view of the Government’s changes to the IFHP by highlighting the positions of medical associations and refugees. The article featured the organized protests the medical association and the personal stories of refugees directly affected by the health insurance cuts.

In addition, other media sources ran pieces openly criticising the Government and questioning the political motivations behind the changes. *The Globe and Mail* (2013) ran the following headline: “Seeking savings, Ottawa takes short-sighted view on refugees’ health care” and *The National Post* (2014) ran “The refugee health-care decision lays bare Harper’s creed — punitive moral absolutism.” The articles address concerns over the real impact on the changes to the IFHP, such as the long term costs associated with the cuts and the health risks certain groups of refugees are experiencing as a result of refugee health care reform. In addition, the media was also critical of the unilateral approach the Government took in this area of refugee policy.

Media coverage of the recent Federal Court decision ordering the Government to amend the changes to the IFHP framed the issue based humanitarian and moral obligations. For example, Christie Blatchford (2014) of *The National Post* wrote an article entitled “Government policy on refugee health care exposed as heartless and shameful,” whereby Blatchford raises an important question for the Government concerning whether Canada is moving away from its long-standing commitment to humanitarian relief, as well as Canada’s commitment to affordable health care.

As a result from the strong opposition from various groups framing refugee reform policy in terms of humanitarian and moral responsibilities, it is unclear whether efforts of the Government to shift refugee health policy will be successful. Opponents have fought back to shift the political discourse away from frames based on fairness, cost and deterrence. In addition, provincial governments and the Federal Court have also opening criticized the Government’s political motivations.

VII. Conclusion

On April 2012, the Government of Canada announced changes to the Interim Federal Health Program, resulting in the reduction of health insurance coverage for certain groups of refugees, including privately sponsored refugees and asylum seekers who receive both a positive or negative decision on their claim. The changes sparked strong opposition from medical professionals, legal groups, community organizations, human rights groups, refugees, as well as

the provincial governments as many refugees were left without means to affordably access medical services.

Despite a Federal Court ruling in favour of reversing the Government's IFHP reform, the Government remains committed to upholding its refugee health policy. The Government stands by its decision affirming that Canada should not extend medical insurance to certain refugees that goes beyond insurance covered by provincial and territory medical insurance most Canadians are eligible to receive. Furthermore, the changes to refugee health coverage also coincide with changes to refugee applications processes and regulations, most notably the introduction of the Designated Country of Origin list. These measures are meant to reduce refugee claims, particularly asylum claims and prioritize government-assisted refugees over other forms of refugees, such as privately-sponsored refugees.

This paper investigated the question: Why did Canada reform refugee health care policy despite strong opposition? And what do these changes signify for the future of refugee policy in Canada? By undergoing a comparative analysis of the American refugee health policy we can conclude that shifting policy frames in the United States and Canada have narrowed the definition of legitimate refugees in both countries.

This paper finds similar refugee framing by right-wing conservative governments in the United States and Canada in order to narrow the definition of legitimate refugee, as well as the public services these groups are entitled to receive. Canada is moving to frame legitimate refugees as resettled refugees, and frame asylum seekers as illegitimate. Policies in the United States and Canada have placed greater restrictions on asylum claims, drawing parallels in the

ways legitimate refugees are framed. In the American case UNHCR ratified refugees were given first priority for state-funded medical insurance. Conversely, asylum seekers faced a higher burden to prove refugee status and were not subject to the same eligibility for state services. The changes to the refugee health policy in Canada emulate this similar perspective when it comes to who is eligible for Extended Health Care Coverage.

Furthermore, in the Canadian context the resistance of the Government to amend the highly contentious refugee health reform suggests a strong political motivation. Evidence suggests that the Canadian government's decision to cut refugee health insurance is largely politically motivated. Opponents have made strong arguments against the federal government's decision, which have been sufficient for six provinces to fill in the gap for certain services among affected refugee groups.

However, the Government continues to support its decision and the framing in way legitimate and "bogus" refugees have been framed suggest that this government will continue to narrow the definition refugees in Canada, having important implications for future refugee intake in Canada. Framing the changes to refugee health care as fair may draw political support; however, strong opposition from the courts and provinces suggests the future of refugee health policy is not set in stone. Ongoing research is required to monitor which prevailing policy frames will guide the future of refugee health care in Canada.

References

- Bell, Stewart. (2012). Few refugees recognized from Sun Sea, Ocean Lady. *The National Post*. Retrieved from <http://news.nationalpost.com/2012/02/06/few-refugees-recognized-from-sun-sea-ocean-lady/>.
- Blatchford, Christie. (2014). Government policy on refugee health care exposed as heartless and shameful. *The National Post*. Retrieved from <http://fullcomment.nationalpost.com/2014/07/04/christie-blatchford-government-policy-on-refugee-health-care-exposed-as-heartless-and-shameful/>
- Brennan, Richard. (2012). Refugees will die if health care cuts go ahead Ontario nurses say. *The Star*. Retrieved from http://www.thestar.com/news/canada/2012/05/31/refugees_will_die_if_health_care_cuts_go_ahead_ontario_nurses_say.html.
- Bruno, Andorra. (2014). Congressional Research Service, Refugee Admissions and Resettlement Policy. Retrieved from <http://fas.org/sgp/crs/misc/RL31269.pdf>
- Cairney, Paul. (2013). Policy Concepts in 1000 Words: Policy Transfer and Learning. Retrieved from <http://paulcairney.wordpress.com/2013/11/11/policy-concepts-in-1000-words-policy-transfer-and-learning/>
- Canadian Council for Refugees. (2012). Refugee Health Care: Impacts of recent cuts. Retrieved from <http://ccrweb.ca/en/refugee-health-care-impacts-recent-cuts>
- Canadian Healthcare Association. (2012). Changes to the Interim Federal Health Program: Position Statement. Retrieved from <http://www.cha.ca/wp-content/uploads/2012/11/IFHP-reform-policy-statement-November-2012.pdf>
- Canadian Press. (2012). Immigration Minister Jason Kenney asks Canadians to thank him for cuts to refugee health benefits. *National Post*. Retrieved from <http://news.nationalpost.com/2012/07/09/immigration-minister-jason-kenney-asks-canadians-to-thank-him-for-cuts-to-refugee-health-benefits/>
- CICS News Team. (2013). Statistics Show Bogus Asylum Seekers Racking Up Health Care Costs. Retrieved from <http://www.cicsnews.com/?p=1216>.
- Citizenship and Immigration Canada. (2013). Backgrounder — Designated Countries of Origin. Retrieved from <http://www.cic.gc.ca/english/refugees/reform-safe.asp>

- Citizenship and Immigration Canada. (2013). Information Sheet for Interim Federal Health Program Beneficiaries. Retrieved from <http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp>
- Citizenship and Immigration Canada. (2012). The Refugee System in Canada. Retrieved from <http://www.cic.gc.ca/english/refugees/canada.asp>
- Department of Homeland Security. Yearbook of Immigration Statistics: 2012. Retrieved from <http://www.dhs.gov/yearbook-immigration-statistics-2012-refugees-and-asylees>
- Dolowitz, David. & Marsh, David. (2000) ‘Learning From Abroad: The Role of Policy Transfer in Contemporary Policy Making.’ *Governance* 13 (1): 5-24.
- Empire Justice. (2008). Community migrant and Homeless Health Center Handbook, Immigrant Eligibility for Publically Funded Health Care benefits Retrieved from <http://www.empirejustice.org/assets/pdf/issue-areas/immigrant-rights/immigrant-eligibility.pdf>
- Fabbrini, S., & Diberé Molutsi, P. 2011. Comparative politics. In B. Badie, D. Berg-Schlosser, & L. Morlino (Eds.), *International encyclopedia of political science*. (pp. 343-360). Retrieved from <http://dx.doi.org/10.4135/9781412959636.n86>
- Federation for American Immigration Reform. (2012). Immigration Issues. Retrieved from <http://www.fairus.org/issues/illegal-immigration>
- Fox News. (2014). New England mayors call for refugee resettlement freeze. *Fox News*. Retrieved from <http://www.foxnews.com/politics/2014/06/23/new-england-mayors-call-for-refugee-resettlement-freeze>
- Friesen, Joe. (2012). Canada Ready to Open its Door to More Immigrants, Kenney Says. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/news/national/time-to-lead/canada-ready-to-open-its-doors-to-more-immigrants-kenney-says/article4178908/>
- Goar, Carol. (2012). Doctors fight to save refugee health benefits. *The Star*. Retrieved from http://www.thestar.com/opinion/editorialopinion/2012/08/02/doctors_fight_to_save_refugee_health_benefits.html.
- Gallup Politics. (2014). One in Six Say Immigration Most Important U.S. Problem. Retrieved from <http://www.gallup.com/poll/173306/one-six-say-immigration-important-problem.aspx>.

- Human Watch. (2013). US: Catch-22 for Asylum Seekers. Retrieved from <http://www.hrw.org/news/2013/11/12/us-catch-22-asylum-seekers>
- Jones, Allison. (2013). Doctors' group takes Ottawa to court over refugee health-care cuts. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/news/politics/doctors-group-takes-ottawa-to-court-over-refugee-health-care-cuts/article9047552/>
- Kay, Johnathan. (2014). The refugee health-care decision lays bare Harper's creed — punitive moral absolutism. *The National Post*. Retrieved from <http://fullcomment.nationalpost.com/2014/07/07/jonathan-kay-the-refugee-health-care-decision-lays-bare-harpers-creed-punitive-moral-absolutism/>.
- Kerwin, Donald. US Refugee Protection Policy Ten Years After 9/11. Retrieved from http://law.psu.edu/_file/Immigrants/9_11_Effect_Online_Publication.pdf
- Keung, Nicholas. (2013). Impact of refugee health cuts: Confusion, unnecessary costs and compromised care. *The Star*. Retrieved from http://www.thestar.com/news/canada/2012/09/28/impact_of_refugee_health_cuts_confusion_unnecessary_costs_and_compromised_care.html#.
- Keung, Nicholas. (2013). Roma refugees: Canadian billboards in Hungary warn of deportation. *The Star*. Retrieved from http://www.thestar.com/news/canada/2013/01/25/roma_refugees_canadian_billboards_in_hungary_warn_of_deportation.html
- Lijphart, Arend. 1971. "Comparative Politics and the Comparative Method." *The American Political Science Review*. 65 (3): 682-693. Retrieved from <http://www.jstor.org/stable/1955513>
- Lim, Timothy. 2010. *Doing Comparative Politics: An Introduction to Approaches and Issues*. 2nd ed. Boulder, Colo: Lynne Rienner Publishers.
- Maioni, Antonia. 2012. "Health Care" in H. Bakvis and G. Skogstad, *Canadian Federalism: Performance, Effectiveness, and Legitimacy*, Third Edition. Don Mills: Oxford, pp. 165-182.
- Mas, Susana. (2014). Chris Alexander scolds Ontario over health care to refugees. CBC News. Retrieved from <http://www.cbc.ca/news/politics/chris-alexander-scolds-ontario-over-health-care-to-refugees-1.2507008>

- Medavie Blue Cross. Interim Federal Health Program. Retrieved from https://www.medavie.bluecross.ca/cs/ContentServer?c=ContentPage_P&pagename=IFHP_CIC_Public%2FContentPage_P%2FIFHP_CICOneColumnFull&cid=1181930640468
- MIPEX. (2010). Radar Graph Canada and the United States 2010. Retrieved from <http://www.mipex.eu/play/radar.php>
- Open Parliament. 2013. 41st Parliament, Bill C-31 (Historical) Protecting Canada's Immigration Systems Act. <http://openparliament.ca/bills/41-1/C-31/>
- Pew Research Center. (2013). Number of Latino children caught trying to enter U.S. nearly doubles in less than a year. Retrieved from <http://www.pewresearch.org/fact-tank/2014/06/10/number-of-latino-children-caught-trying-to-enter-u-s-nearly-doubles-in-less-than-a-year/>
- Picard, Andre. Seeking savings, Ottawa takes short-sighted view on refugees' health care. *The Globe and Mail* 2013, July 18. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/health/seeking-savings-ottawa-takes-short-sighted-view-on-refugees-health-care/article13293421/>
- Playton, Lauren. (2014). Federal Government to Appeal Ruling Reversing 'cruel' cuts to Refugee Health. *CBC News*. Retrieved from <http://www.cbc.ca/news/politics/federal-government-to-appeal-ruling-reversing-cruel-cuts-to-refugee-health-1.2696311>
- Preston, Julia. (2013). Number of Illegal Immigrants in U.S. May Be on Rise Again, Estimates Say. *New York Times*. Retrieved from http://www.nytimes.com/2013/09/24/us/immigrant-population-shows-signs-of-growth-estimates-show.html?_r=0
- Ragin, C., & Rubinson, C. (2011). Comparative methods. In B. Badie, D. Berg-Schlosser, & L. Morlino (Eds.), *International encyclopedia of political science*. (pp. 332-342). Thousand Oaks, CA: SAGE Publications, Inc. doi: <http://dx.doi.org/10.4135/9781412959636.n85>
- Raza, Danyaal, Meb Rashid, Lynda Redwood-Campbell, Katherine Rouleau, and Phillip Berger. 2012. "A Moral Duty Why Canada's Cuts to Refugee Health Must Be Reversed." *Canadian Family Physician* 58(7):728-29.
- Redmon, Jeremy. (2014). Limits placed on refugee coming to Georgia. *The Atlanta Journal-Constitution*. Retrieved from http://www.myajc.com/news/news/state-regional-govt-politics/limits-placed-on-refugees-coming-to-georgia/ndG7m/?icmp=ajc_internallink_invitationbox_apr2013_ajcstubtomyajcpremium

Refugee Council USA. (2014). Refugee Definition. Retrieved from <http://www.rcusa.org/us-refugee-definition>

Respetro, Dan and Garcia, Ann. (2014). The Surge of Unaccompanied Children from Central America, Root Causes and Policy Solutions. Retrieved from <http://www.americanprogress.org/issues/immigration/report/2014/07/24/94396/the-surge-of-unaccompanied-children-from-central-america-root-causes-and-policy-solutions/>.

Simpson, Jeffrey. 2012. *Chronic Condition, Why Canada's Health-Care System Needs to be Dragged into the 21st Century*. Toronto: Penguin Group.

Swedlove, Frank. (2013). Frank Swedlove: The hidden health-care crisis. *The National Post*. Retrieved from <http://fullcomment.nationalpost.com/2013/09/17/frank-swedlove-the-hidden-health-care-crisis/>

Standbrooke, Matthew. (2014). "Canada owes refugees adequate health coverage," *CMAJ: Canadian Medical Association Journal*, 186(2), 91. Retrieved from <http://go.galegroup.com/ps/i.do?id=GALE%7CA361242154&v=2.1&u=otta77973&it=r&p=AONE&sw=w&asid=fd26cd559365e2f6ece4d53cb200423e>

The Guardian. (2014). Immigration poll reveals partisan rift over Central American refugees. *The Guardian*. Retrieved from <http://www.theguardian.com/world/2014/jul/30/immigration-poll-central-america-refugees>

US Department of Health and Human Services. (2014). History, Annual Refugee Arrival Data by Resettlement State and Country of Origin. Retrieved from <http://www.acf.hhs.gov/programs/orr/about/history>

US Department of Health and Human Services. (2014). Immigrant families and the Marketplace. Retrieved from <https://www.healthcare.gov/what-do-immigrant-families-need-to-know/>

United States Department of State; United States Department of Homeland Security and United States Department of Health and Human Services. (2014). Proposed Refugee Admissions for Fiscal Year 2014, Report to the Congress. Retrieved from <http://www.state.gov/documents/organization/219137.pdf>.

UN Refugee Agency. (2012). Global Trends, 2012. Retrieved from <http://www.unhcr.org/51bacb0f9.html>

Vargas, Jose Antonio. (2012). Immigration Debate: The Problem with World Illegal. *Time*. Retrieved from <http://ideas.time.com/2012/09/21/immigration-debate-the-problem-with-the-word-illegal/>

Wallace, Isabel. (2014). Timeline of Canada's Refugee Policy. *Ottawa Citizen*. Retrieved from <http://ottawacitizen.com/news/politics/timeline-canadas-refugee-policy>

Appendix

Table 1: American Health Insurance Eligibility by Refugee Status 2014

Type of Public Health Insurance Coverage	Refugee Status
Medical Screening Examination is covered by the Refugee Medical Assistance when examination is within the first 90 days of refugees initial date of entry	For all <i>refugee</i> status even if the refugee is not eligible for Medicaid or RMA
Refugee Medical Assistance (RMA)- for refugees in their first 8 months in the United States	<p>-<i>Refugee</i> are those who have been granted this status before entering the United States</p> <p>-<i>Asylum</i> status refers to those who have been granted this status while present in the United States</p> <p>-<i>Cuban and Haitian Entrant</i> are those who have been granted humanitarian parole or the subject of exclusion or removal proceedings or have an application for asylum pending</p> <p>-<i>Trafficking Victims</i> are non-citizens who have been forced into the international sex trade, prostitutions, slavery and forced labour through coercion, threats of physicals violence, psychological abuse, torture and imprisonment</p>
No Public Health Insurance Plan	<i>Applicant for Asylum</i> is someone who has applied but has not been granted asylee status

Source: Health Care Programs Manual, hcopub.dhs.state.mn.us/oo.htm

Table 2: Canadian Medical Insurance Eligibility, Interim Federal Health Program 2012

Type of Public Health Insurance Coverage	Refugee Status under IFHP
--	---------------------------

<p>Expanded Health-Care Coverage & Immigration Medical Examinations This coverage lasts as long as you have a valid TRP.</p>	<p>Victims of Human Trafficking who have been issued a temporary resident permit (TRP) under section 24 of the <i>Immigration and Refugee Protection Act (IRPA)</i>.</p>
<p>Expanded Health-Care Coverage & Immigration Medical Examinations done in Canada This coverage lasts as long as you receive governmental resettlement assistance in the form of income support, up to a maximum of 12 months.</p>	<p>Persons for whom the Minister exercises discretion on his own initiative for humanitarian and compassionate considerations or for public policy considerations, who receive governmental resettlement assistance in the form of income support.</p>
<p>Expanded Health-Care Coverage You will remain eligible for Interim Federal Health Program coverage other than doctor and hospital care as long as you receive income support from a governmental resettlement assistance program, or are under a private sponsorship.</p>	<p>Resettled refugees who are or were receiving governmental resettlement assistance in the form of income support. This group consists of: government-assisted refugees and other refugees who are receiving governmental resettlement assistance in the form of income support, including Visa-Office Referred refugees and refugees coming to Canada through the Joint Assistance Sponsorship Program.</p>
<p>Health-Care Coverage & Immigration Medical Examinations This coverage lasts as long as you are a refugee claimant, unless your claim is suspended, or you become a rejected refugee</p>	<p>Refugee claimants who are not from a Designated Country of Origin (DCO) (this includes those where there is a judicial review or appeal of the IRB decision pending)</p>
<p>Health-Care Coverage You will remain eligible for covered medications and vaccines needed to prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern, as long as you are under private sponsorship.</p>	<p>Resettled refugees while under sponsorship that do not receive, and have not received governmental resettlement assistance in the form of income support.</p>

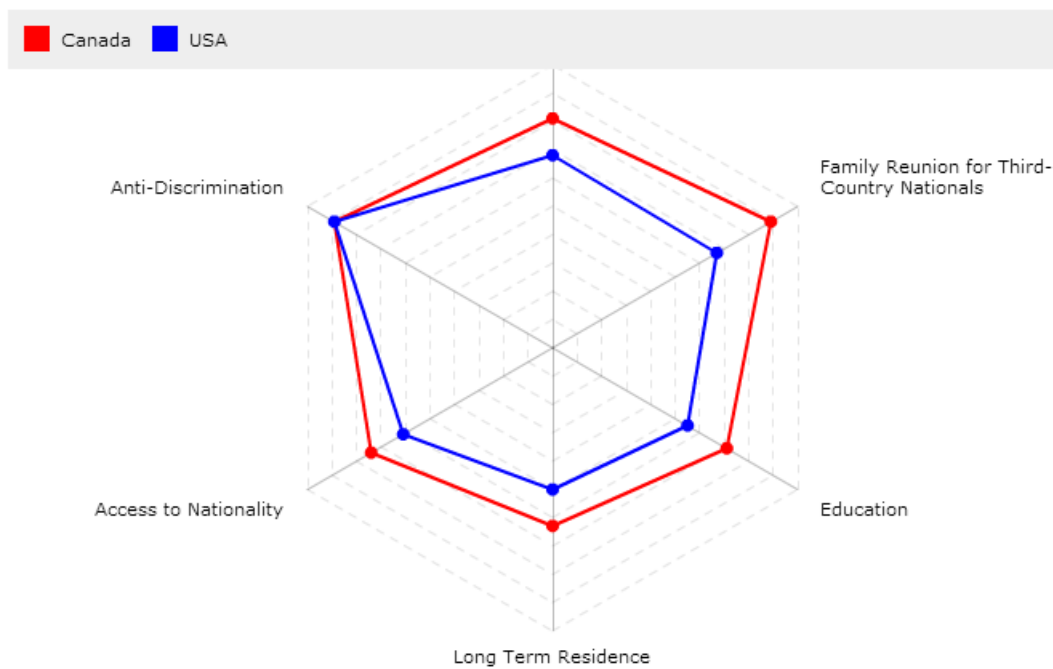
<p>Health-Care Coverage</p>	<p>Protected persons (other than resettled refugees) This group includes people who receive a positive decision on their refugee claim from the Immigration and Refugee Board (IRB) and most people who receive a positive decision on their pre-removal risk assessment (PRRA).</p>
<p>Public Health or Public Safety Health-Care Coverage & Immigration Medical Examinations This coverage lasts as long as you are a refugee claimant, unless your claim is suspended, or you become a rejected refugee claimant</p>	<p>Refugee claimants who are from a DCO</p>
<p>Public Health or Public Safety Health-Care Coverage & Immigration Medical Examinations This coverage lasts as long as your claim is suspended.</p>	<p>People whose refugee claim has been suspended</p>
<p>Public Health or Public Safety Health-Care Coverage This coverage lasts until you leave Canada voluntarily or your removal order has been enforced.</p>	<p>Rejected refugee claimants This group includes people whose claim:</p> <ul style="list-style-type: none"> • is rejected and the decision is not appealed • is rejected and a leave application for judicial review is denied, or the judicial review of a rejected claim is denied, or any further appeal is denied.
<p>Coverage for Detainees & Immigration Medical Examinations This coverage lasts as long as you are detained.</p>	<p>Persons who are detained under the <i>Immigration and Refugee Protection Act</i> (IRPA).</p>

Source: Citizenship and Immigration Canada, Information Sheet For Interim Federal Health Program Beneficiaries, <http://www.cic.gc.ca/english/refugees/outside/ifhp-info-sheet.asp>

Table 3: Refugee Arrivals: Fiscal Years 1980 to 2012

Year	Number
1980	207,116
1981	159,252
1982	98,096
1983	61,218
1984	70,393
1985	67,704
1986	62,146
1987	64,528
1988	76,483
1989	107,070
1990	122,066
1991	113,389
1992	115,548
1993	114,181
1994	111,680
1995	98,973
1996	75,421
1997	69,653
1998	76,712
1999	85,285
2000	72,143
2001	68,925
2002	26,788
2003	28,286
2004	52,840
2005	53,738
2006	41,094
2007	48,218
2008	60,107
2009	74,602
2010	73,293
2011	56,384
2012	58,179

Source: U.S. Department of State, Bureau of Population, Refugees, and Migration,
<http://www.dhs.gov/yearbook-immigration-statistics-2012-refugees-and-asylees>

Figure 1: MIPEX Radar Graph Canada and USA Score 2010

Source: Migration Policy Index, MIPEX Radar Graph Canada and USA 2010,
<http://www.mipex.eu/play/radar.php>