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REVIEW PAPER

Health Inequity and "Restoring Fairness" Through the Canadian Refugee Health Policy Reforms: A Literature Review

Valentina Antonipillai[1] · **Andrea Baumann**[1,2] · **Andrea Hunter**[1,3] · **Olive Wahoush**[1,2] · **Timothy O'Shea**[1,4]

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Abstract Refugees and refugee claimants experience increased health needs upon arrival in Canada. The Federal Government funded the Interim Federal Health Program (IFHP) since 1957, ensuring comprehensive healthcare insurance for all refugees and refugee claimants seeking protection in Canada. Over the past 4 years, the Canadian government implemented restrictions to essential healthcare services through retrenchments to the IFHP. This paper will review the IFHP, in conjunction with other immigration policies, to explore the issues associated with providing inequitable access to healthcare for refugee populations. It will examine changes made to the IFHP in 2012 and in response to the federal court decision in 2014. Findings of the review indicate that the retrenchments to the 2012 IFHP instigated health outcome disparities, social exclusion and increased costs for vulnerable refugee populations. The 2014 reforms reinstated some services; however the policy continued to produce inequitable healthcare access for some refugees and refugee claimants.

Keywords Refugee health policy · Interim Federal Health Program · Canada · Refugees · Refugee claimants

Introduction

Forced migration is growing in volume and significance due to endemic violence and human rights violations [1]. One of the fundamental causes for increased refugee mobility is derived from the amplified number of conflicts that have become more protracted and in some cases, persisted for decades [2]. Countries, such as Syria, Somalia, Afghanistan, Congo and Sudan, exhibit ongoing conflicts with little prospect of an end. As a result, these countries produce mass outflows of individuals seeking a safe haven for their well-being and that of their families [3]. Between 1975 and 2003, the global refugee population grew from 2.4 million to 10.4 million [4]. Currently, the United Nations High Commissioner for Refugees (UNHCR) reports that there are 59.5 million forcibly displaced migrants worldwide; 19.5 million of these migrants are refugees [1].

Canada has been at the forefront of welcoming refugees and immigrants across the globe for decades [5]. However, over the past 4 years, state imposed restrictions have severely limited the global movement of refugees into Canada [6]. In 2012, changes to Canada's refugee policy were introduced through Bill C-31, an *Act to amend the Immigration and Refugee Protection Act*, and the Interim Federal Health Program (IFHP) as the Order in Council (OIC): *order respecting the IFHP* [7, 8]. These major policy reforms implemented constraints on some categories of refugees, deeming them ineligible to access sources of care and support offered to other categories [9]. For example, refugee claimants arriving from a certain country would not

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✉ Valentina Antonipillai
antoniv@mcmaster.ca

[1] Global Health, McMaster University, Hamilton, ON, Canada

[2] School of Nursing, McMaster University, Hamilton, ON, Canada

[3] Paediatrics, McMaster University, Hamilton, ON, Canada

[4] School of Medicine, McMaster University, Hamilton, ON, Canada

be covered for any healthcare services unless their illness was a threat to public health. Bill C-31 introduced the legislation determining which refugees from specific countries of origin would be excluded from receiving healthcare and the opportunity to work [7, 9].

The IFHP changes greatly reduced healthcare coverage for refugee populations, resulting in the loss of medical care and hospital service provisions for many who had previously been covered [10]. Moreover, these refugee policy reforms have stimulated a great reduction in the number of new refugee claimant arrivals in Canada [6]. In 2012, Citizenship and Immigration, Canada (CIC) reported 20,469 in-land applications were received by the Canadian government while, only 10,380 applications were submitted in 2013 [11]. This is the lowest number of refugee claimants applying for asylum within 20 years of available data in Canada, at a time when the numbers of refugees and refugee claimants are globally rising [11]. This paper provides a review of the IFHP and Bill C-31, utilizing the government's reasons for implementing the 2012 IFHP reforms to examine impacts on the health equity of refugee populations. This review reveals the provision of inequitable healthcare for refugees and refugee claimants during the 4 year-long reforms and explores the changes made to the IFHP in response to the federal court decision in 2014.

Methods

A literature search of Medline, Pubmed, Pubmed Central, Web of Science, Google Scholar and Proquest, was carried out from November 2014 to April 2015 for articles that observed the effects of the IFHP reforms on refugee health in Canada. The existing literature (n = 12) that addressed this topic comprised of peer-reviewed studies, commentaries and discussion papers (Appendix 1). Articles that met the following criteria were included: (1) articles focused on refugee and claimant population, (2) outcomes related to refugee and/or claimant health or well-being, (3) the articles addressed or reviewed effects of the IFHP reforms or related immigration policies (Bill C-31) on refugee/claimant health or access to healthcare, (4) the articles were published in English or French. The database searches resulted in 159 hits. six records were identified through other sources, for a total of 165 records. 78 records remained after duplicates were removed. 12 peer-reviewed articles met inclusion criteria (Fig. 1).

As the existing evidence of the impacts of the IFHP reforms on refugee populations was limited, a broader literature search was conducted to examine refugee health in Canada, based on the reasons by the Canadian government to introduce the IFHP reforms: (1) To contain the cost, (2) to reaffirm precariousness, (3) to protect public health and safety (4) to ensure fairness to Canadians, (5) to defend the refugee determination system [12]. A literature search using the six databases was conducted for articles pertaining to refugee and claimant health in Canada, including the impact on their health by immigration and immigration policy. Terms and key words used for the searches included a combination of the following: refugee, refugee claimant, asylum-seeker, health, healthcare access, provision, immigration policy, IFHP reforms, IFHP, Bill C-31, health policy, refugee determination system, and Canada.

Articles were excluded according to the following criteria: (1) The article referred to work that was reported more fully elsewhere, (2) the article was in a language other than French or English (3) the report was not published. 24 peer-reviewed articles were identified, and three articles obtained from other sources. Overall, the literature consisted of peer-reviewed studies, discussion papers, advocacy group reports, institutional policy equity reports and commentaries (Appendix 1). As the study of refugee health policy entails an interdisciplinary outlook, policy summaries from government websites, media articles, case laws involving the IFHP reforms and immigration policies, as well as statistical data from the Canadian government and international organizations are incorporated into this review.

Review

Review of Immigration Policy

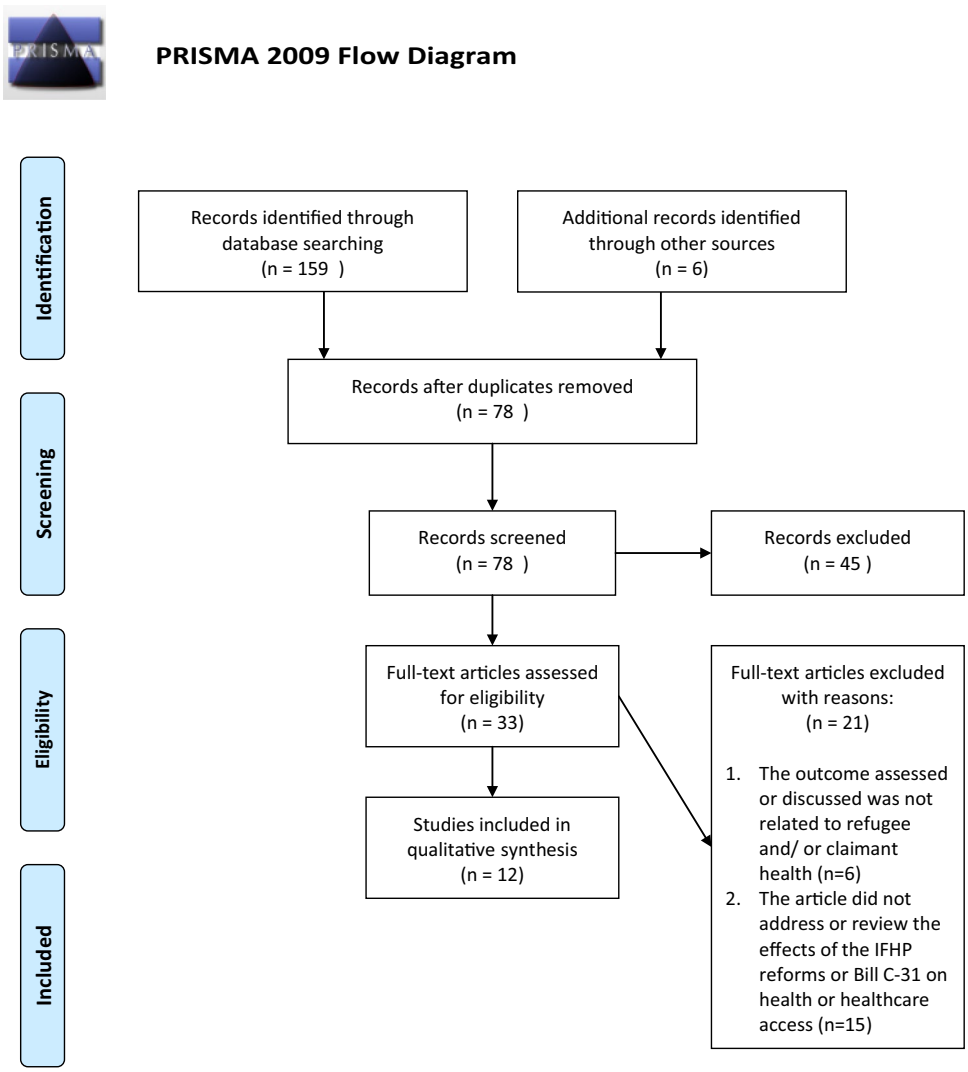
The Canadian Context

Throughout history, Canada has constructed its identity on the foundation of human rights protection, through the formation of the Charter of Rights and Freedoms, multiculturalism, as well as a notable immigration history [5]. As a signatory to the 1951 UN Convention, the 1966 International Covenant on Civil and Political Rights and the 1967 Protocol on Refugees, Canada assumed its legal obligation to grant protection to Convention refugees and persons in need of protection. However, before an individual claiming refugee status is recognized as a Convention refugee or a person in need of protection, their claims must be evaluated through the refugee determination process [11].

In Canada, individuals arriving as Convention refugees (their claim investigated and accepted outside) are provided with permanent landed residency upon arrival. According to 1951 Convention Relating to the Status of Refugees, recognition as a Convention refugee means that individuals have been able to prove they are persons:

> Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of

Fig. 1 PRISMA 2009 flow diagram



> a particular social group or political opinion, is outside the country of his nationality and is unable or, due to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country where he/she normally lives, is unable or, due to such fear, is unwilling to return to it. [13].

The government of Canada and UNHCR acknowledge that an asylum seeker, or refugee claimant, is an in-land refugee applicant whose claim has yet to be determined. In-land claimants have temporary status if they are eligible for review, and receive protection only if they are found to be a Convention refugee according to the terms of the 1967 Protocol relating to the Status of Refugees definition or found to be a person in need of protection. The latter is defined as: " a person in Canada whose removal to their country or countries of nationality or, if they do not have a country of nationality, their country of former habitual residence, would subject them personally to a danger, believed on substantial grounds to exist… or to a risk to their life or to a risk of cruel and unusual treatment or punishment" [14].

A Federal Court decision in 1985 [15] created a refugee determination system that allowed refugee claimants to represent their cases on an individual basis to a government official, thus promoting a more nuanced decision-making process to integrate refugees into Canadian society [16]. In 1986, Canada was awarded the Nansen medal for its context-specific refugee determination approach and applauded for its efforts to assist refugees in becoming permanent, contributing members of Canadian society [5] (Fig. 2).

According to the UNHCR, in 2008 and 2009 Canada was the second and third highest destination country for asylum-seekers, respectively, of the top 44 industrialized countries. However, Canada's ranking dropped to 16th place by 2013 as newly registered asylum-seekers were reduced by two-thirds which is, "potentially the result of recent reforms of asylum policies and the introduction of visa requirements for some nationalities featuring among the major groups of asylum seekers in Canada" [6]. The recent reforms to

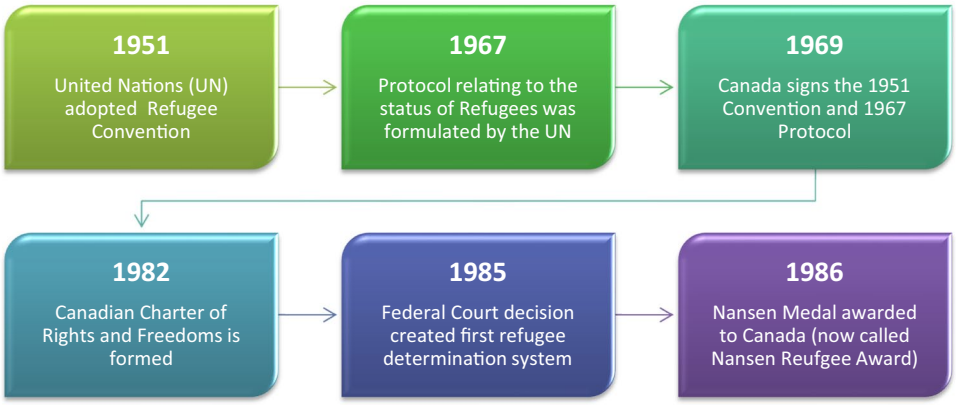


Fig. 2 Timeline of Canadian immigration history from 1950 to 1990

asylum policies, reported by the UNHCR, include the introduction of Bill C-31 and the changes to the IFHP in 2012.

Introduction of Bill C-31

Under the reforms made through Bill C-31, two different categories of inland refugee claimants were established: refugee claimants from a Designated Country of Origin (DCO) and those from a non-Designated Country of Origin (non-DCO) [7]. Bill C-31 differentiated between refugees from DCOs and non-DCOs, enabling the Canadian government to exercise sovereignty through the control of immigration by limiting the entry of refugee claimants into the nation [7]. Refugees from DCO countries are subject to shorter claim processing timelines, prohibited from appealing failed refugee claims, and if their claim for refugee status has been denied, they cannot reapply invoking humanitarian and compassionate grounds for up to 1 year [17]. According to recent reports, the largest proportion of refugees who enter Canada seeking asylum flee from Mexico and Hungary, both countries listed as DCOs by the Minister of Citizenship and Immigration [11].

The Minister of Citizenship and Immigration has the authority to designate countries as safe based on the Minister's subjective opinion that the country may have independent judicial and legal rights in place for the refugee [17, 18]. As a result, the decision that a country is safe is founded on the subjective discretion of the Minister, who may overlook the hidden crisis of violence in the nation experienced by the refugee claimants, such as domestic abuse of women, requiring them to seek protection elsewhere [19]. According to the executive director of the Barbara Schlifer Clinic, "these provisions fail to recognize that women may experience systemic discrimination and unchecked gender based violence in countries otherwise considered safe… such as places like Portugal, St. Vincent and Mexico to name a few… under Bill C-31, they would likely be forced to return to that violence" [20].

As part of developing a faster refugee determination process, individuals from DCOs are faced shorter timelines for processing refugee claims. The Basis of Claim form limits their period to gather documentation to 30 days, as opposed to 60 days for other refugee claimants [18]. As a result, these reforms increase the likelihood that DCO refugee claims will not be successful with the limited preparation time, and once denied, these individuals are prohibited to appeal to the Refugee Appeal Division (RAD) [21]. Moreover, all individuals who apply for refugee status are required to wait at least 1 year after receiving a negative decision before filing a humanitarian and compassionate application [21]. Therefore, by prolonging the determination of legal status, these individuals are subject to a more precarious experience in Canada [22].

The lack of permanent legal status or citizenship impacts eligibility for work as refugees from DCOs cannot apply for work permits until their refugee claims are accepted or 180 days have passed since their claims were referred to the Immigration and Refugee Board (IRB) of Canada [12, 17]. Moreover, precarious status promotes the constant threat of detention and deportation in refugee claimants' lives. This additional anxiety leads to the increased prevalence of mental health disorders among refugee claimants [23–25]. Refugees and refugee claimants turn to Canada's healthcare system for support during their first few years of integration [26].

Review of Interim Federal Health Program Changes

IFHP 2012 Legislative Changes

Refugees newly arriving to Canada are required by the majority of provincial health authorities to observe a waiting period of three months before they are eligible to access provincially funded health plans, which usually cover physician and hospital use while excluding drug, oral and vision coverage [27, 28]. Private health insurance is usually available to bridge the gap of coverage between arrival and access to provincial healthcare, but it is a costly alternative for most refugees and refugee claimants. Most refugees and

claimants in Canada have experienced the hardships of violence forcing them to generally migrate from low-income countries and arrive with little resources, resulting in their increased reliance on public coverage provided by the IFHP [3]. However, in 2012 reforms to the IFHP complicated and limited care, negatively impacting this vulnerable population, healthcare providers and other stakeholders involved in refugee care [29].

The Canadian government funded the IFHP since 1957 ensuring comprehensive healthcare insurance for all refugees and refugee claimants seeking protection in Canada for over 50 years [12]. Prior to the 2012 changes, identical IFHP healthcare coverage was available for government-assisted refugees (GARs), privately-sponsored refugees (PSRs), protected persons, refugee claimants and refused refugee claimants with negative decisions under appeal, review or those awaiting deportation [12]. Each individual, regardless of claim approval or country of origin, was provided with complete healthcare coverage, including supplementary and drug coverage, to ensure equitable treatment of vulnerable individuals seeking humanitarian aid on Canadian soil.

Under the reforms made through the 2012 IFHP, however, migrants were separated into categories influenced by Bill C-31 and were provided with varying levels of coverage depending on their country of origin and immigration status. Refugee claimants from any of the 37 DCO listed by the Canadian government as respecting human rights and offering safe protection would receive limited access to healthcare services upon arrival to Canada. The IFHP reforms segregated health insurance into three tiers of medical coverage assigned to the different categories of refugees: expanded health care coverage (EHCC), Health care coverage (HCC) and public health or public safety health care coverage (PHPS).

The first tier, EHCC, was available to GARs and provided healthcare coverage equivalent to the pre-2012 IFHP coverage, in which hospital and physician services, dental, vision, vaccinations and medications were covered [7]. The second tier, HCC, was available for PSRs and refugee claimants who did not enter Canada from a DCO [30]. It delivered basic healthcare coverage of physician, nurse and hospital services as well as laboratory and diagnostic care. However, medication and vaccines were only covered if there was a requirement to treat the disease if it posed a risk to public health or a condition of public safety concern [9]. The third tier, PHPS, was provided to failed refugee claimants and claimants from DCOs [30]. It substantially limited the provision of all care and services. Medication and immunization were provided only if they were required to "to diagnose, prevent or treat a disease posing a risk to public health or… a condition of public safety concern" such as HIV or active pulmonary tuberculosis [12, 29].

Essentially, the reforms restricted access to medications and supplementary coverage (e.g., dental and vision). In-land refugee claimants from Designated Countries of Origin (DCO) would only receive medical attention if their conditions were deemed of to be of an "urgent and essential nature," posed a threat to public health or became a concern of public safety [31]. As a result, pregnant women have been denied prenatal and obstetrical care, those with chronic illnesses such as cancer have been refused chemotherapy and even a young child with a fever and cough was denied access to diagnostic care, such as a chest x-ray, to determine whether the child was suffering from pneumonia, a life-threatening disease [12].

Reaction to the 2012 Reforms

Concerns for refugees and refugee claimants voiced by Canadian health organizations and professionals over a period of 2 years (2012–2014) prompted the federal court to reassess the impact of these reforms on all stakeholders involved in refugee care, including physicians, lawyers, pharmacists and refugee claimants themselves. Within one month of the introduction of the 2012 IFHP reforms, eight national health provider associations expressed their concerns and opposition to the changes [32, 33]. The associations included the College of Family Physicians Canada, Royal College of Physicians and Surgeons of Canada, Canadian Association of Optometrists, Canadian Association of Social Workers, Canadian Dental Association, Canadian Medical Association, Canadian Nurses Association and Canadian Pharmacists Association. Some local municipalities agreed to forgo the significant rollback to the IFHP as early as May 16, 2012 and continued, "to fund refugee health care programs" [34].

On February 25, 2013, a legal challenge launched by the Canadian Doctors for Refugee Care (CDRC), joined by the Canadian Association for Refugee Lawyers (CARL) and three patients, was successfully appealed to the Federal Court of Canada, who deemed that the cuts to the IFHP carried out unjust treatment of refugees and refugee claimants [35]. Prior to the court ruling in favour of the CDRC to restore refugee health coverage, that largest refugee-receiving province, Ontario, launched a provincial health insurance plan for refugee populations in January, 2014. The Ontario Temporary Health Program (OTHP) provides, "essential and urgent healthcare, as well as medication coverage," to refugees and claimants residing in Ontario [36]. Ontario is the sixth province to fill the gap left by the federal health reforms through the introduction of the OTHP after Manitoba, Saskatchewan, Quebec, Nova Scotia and Alberta [37]. According to the CIC, reforms to the IFHP were introduced to accomplish the following:

(1) Modernize, clarify and reaffirm the original intent of the IFHP as a temporary… program, (2) Alter the IFHP protocol to ensure "fairness to Canadians," (3) Protect Public Health and Public Safety in Canada, (4) Defend the integrity

of Canada's refugee determination system and deter its 'abuse' and (5) Contain the financial cost of the IFHP [12].

These explanations have been overruled by Justice McTavish's court decision that the IFHP reforms violated section 12 of the Canadian Charter of Rights by carrying out "cruel and unusual treatment" of vulnerable refugee populations [12]. In the following sections, the federal government's objectives for implementing the IFHP retrenchments will be examined using the literature to review the impact on refugee populations' health equity.

Objective One: Temporary Program

The primary objective of the IFHP cuts was to promote the implementation of a temporary system for all refugee claimants in an attempt to "modernize, clarify and reaffirm the [IFHP's] original intent" [12]. Instead, the temporary IFHP restricted health services to refugees, promoting poor health outcomes for refugee claimants by exacerbating existing barriers to access the healthcare system [29].

Studies in Canada have found that refugees frequently face difficulties accessing healthcare due to a combination of barriers including language, transportation, cultural differences and precarious legal status [22, 27]. Discrimination is another barrier to accessing healthcare, as refugee mothers reported perceiving discriminatory attitudes and experiences from their healthcare providers [38]. Socioeconomic factors, such as low income and poor education, compel refugee claimants to avoid seeking healthcare services, "particularly in the face of healthcare restructuring" [39].

Refugee claimants may be reluctant to seek healthcare services and may not wish to disclose their medical history for fear of a negative impact on acquiring permanent refugee status in Canada [40]. Refugee claimants may also be discouraged to seek healthcare due to experiences of refusal of care or demands for fees for treatments that should be covered [28, 30, 33, 35]. Some healthcare providers have been reluctant to accept refugee patients due to their complex needs and uncertain IFHP coverage, even prior to the 2012 cutbacks [28]. This phenomenon was exacerbated under the 2012 IFHP reforms; according to emails obtained by the Canadian Medical Association Journal, only nine out of thirty-three walk-in clinics in Ottawa accepted refugees as patients. Moreover, the accepting clinics would charge a visit fee of $60.00 for refugees regardless of coverage [35].

Objective Two: Fairness to Canadians

One reason to introduce retrenchments to healthcare coverage plans for refugees and refugee claimants was to accomplish the second objective of the reforms: to ensure "fairness to Canadians" [12]. This assertion was based on the reasoning that the former program provided more generous benefits than those received by working Canadians by their provincial and territorial programs [41]. However, these reforms did not rationally address the unfairness perceived by Canadians as "it is no fairer to Canadians to now provide vulnerable poor and disadvantaged asylum seekers with a level of health insurance coverage that is [nearly] comparable to that available to working Canadians" [12].

According to the 2012 IFHP cuts, refugee claimants from non-DCOs received basic health care coverage (HCC) and PHPS medication coverage, excluding dental care, walkers, hearing aids, home care, elective surgery or rehabilitation [8]. This category of refugee claimants would receive diagnostic care provided by physicians, nurses and hospitals, and they would be assessed for conditions such as diabetes or cardiovascular disease. However, even if they were successful in their applications for status, once they were diagnosed with an illness no refugee claimant would "receive coverage for medications… like insulin, statins or anti-hypertensive drugs" [33].

Moreover, the provision of PHPS coverage for all refugee claimants from DCOs resulted in a lack of coverage for physician or hospital visits, medications or supplementary care such as vision or dental care. These individuals would only be treated or diagnosed for their condition if their condition was one out of the 24 disorders that were deemed a public health threat or a public safety concern [7].

According to Raza et al. [33], the IFHP cuts "focus on emergency treatment and aggressive infectious conditions among refugees [which] underscores a deep change in the way in which human beings are assigned value according to the social circumstances". Healthcare providers were faced with ethical dilemmas of having to refuse care to those in need due to government legislation defining refugee claimants and distinguishing claimant categories as different from being a Canadian citizen. The "fairness to Canadians" objective positions Canadian citizens against refugees by promoting the perception of refugees as threats of political and economic disruption, instead of recognizing them as a vulnerable group of people [41].

Refugees and refugee claimants have been found to display higher rates of tuberculosis, HIV/AIDS, diabetes and hepatitis B compared to those born in Canada [42–45]. They are also at an increased risk of developing several vaccine-preventable communicable diseases due to under vaccination [43]. When compared to economic or family class immigrants, refugees experience more pronounced mental and physical health complications, particularly during resettlement [46]. Refugee claimant mothers in particular are more likely to be associated with having higher levels of psychosocial risk and unaddressed postnatal concerns than both immigrant and native-born Canadian mothers [47]. Most significantly, compared to other immigrants, refugees are more likely to experience a rapid decline in self-reported

health status after arrival in Canada [43]. Therefore, the retrenchments to healthcare under the IFHP provide inequitable access for the vulnerable populations.

Objective Three: Protecting the Public

The third objective of the IFHP cuts, to "protect Public Health and Public Safety in Canada," is undermined by the consequences and implications of reduced healthcare provision. As mentioned in the previous section, refugees and refugee claimants display increased risk of developing vaccine-preventable communicable diseases [42–45, 48]. As preventative and diagnostic care was inaccessible by this vulnerable group of people due to the IFHP reforms, "health promotion initiatives [became] almost impossible to implement… creating serious public health risks" [29]. Sheikh et al., assert that the reforms posed a threat to public health as, "the federal government has not clarified which clinical presentations or symptoms would justify an investigation to rule out an infection by a transmissible organism (and hence services being covered under the public health category)," [30]. Therefore, achieving the third objective of the 2012 IFHP reforms presented challenges. Reduced coverage would have led to public health risks because certain claimants did not have access to diagnostic care in the event that they were ill with a communicable disease. Overall, there is no evidence that reducing healthcare coverage for refugees and claimants would have protected the health and safety of Canadians.

Objective Four: Defending the System

The fourth objective of the cuts aimed to defend Canada's refugee determination system against refugee claimants who were seeking to 'abuse' the generosity of Canadians [12]. As Minister Kenny claimed, the IFHP reforms would, "stop the abuse of Canada's generous and overburdened healthcare system by bogus refugees" [49]. The term "bogus" created the effect of "othering" refugee claimants by provoking the stereotypical view that they are "cheats" and "queue-jumpers" who have come to Canada to take advantage of the healthcare system [12]. The government's proposition to weed out "bogus" refugees stemmed from the fear of recent global mass refugee movements as a threat to the country's economic resources [41]. The idea that resources are scarce and 'other' refugees compete with 'us', Canadians, for them led to the perception of refugees as a threat which elicited a sovereign response from the Canadian government to implement restrictive refugee policies [41, 50].

Objective Five: Containing the Cost

The final objective of the federal government for implementing the IFHP reforms in 2012 was to "contain the financial cost of the IFHP" [12]. Before the reforms, the IFHP cost was approximately $84 million and covered 128,000 people in 2012 [49]. Following the retrenchment, the federal government expected to save $20 million a year [51]. However, the cost of providing health care for refugee claimants has been reallocated rather than reduced. The reforms have increased emergency department (ED) use, and the cost has been shifted to hospitals under provincial insurance [29, 51].

According to a retrospective chart review of 1063 refugee patients from 2011 to 2014, the burden of chronic diseases such as anemia (25 % among females aged 15 and over), hypertension (30 %), were prevalent among the refugee population [48]. Moreover, the study revealed there was an increased prevalence of intestinal parasites (16 %) and Hepatitis B non-immunity (61 %) among this population [52]. With poor health outcomes, refugee claimants are more likely to visit the ED for concerns that are more serious, exacerbating the long wait times and tightening hospital and provincial healthcare budgets [30].

As reported by Shiek et al.[30], an accepted refugee claimant with asthma did not have coverage under the 2012 IFHP to pay for a bronchodilator. She was rushed to the ED for an asthma exacerbation. The cost of her ED visit and subsequent hospitalization could have been avoided had she been provided with coverage for the proper medication [30]. Moreover, a retrospective chart review and cost analysis at the Hospital for Sick Children assessed ED visits 6 months before and 6 months after the IFHP cuts. The study demonstrated that the number of ED admissions had increased from 6.4 to 12.1 % [51]. However, this result was statistically insignificant due to small sample size.

There is no evidence that the 2012 IFHP reforms reduced or contained the overall cost of care for refugees and refugee claimants. Instead, it has been revealed that the cuts transfer the costs to the vulnerable individuals, hospitals, or the province, which bear the costs of unpaid medical bills [36, 51]. According to the cost analysis at Sick Kids Hospital, after the 2012 IFHP reforms, healthcare costs for the institution significantly increased [51]. Prior to the IFHP cuts, 46 % of ER bills were paid by the IFHP, however, after the cuts, only 7 % were paid by the IFHP. As over 90 % of the ED bills were left unpaid by the government-funded IFHP, this cost was assumed by the healthcare institution [51]. Additionally, provinces have been absorbing certain healthcare costs which were no longer assumed by the federal government, creating a complex system for healthcare providers and refugee claimants to navigate [53].

IFHP 2014 Reforms

The legal challenge, launched by the Canadian Doctors for Refugee Care (CDRC), on the basis of violating section 12 of the Charter of Rights and Freedoms, successfully

justified to the federal court that the cuts to the IFHP was a form of "cruel and unusual" treatment [12]. Furthermore, the court ruled that the 2012 IFH cuts were "of no force or effect" in which refugees and claimants should be provided with "health insurance coverage that is equivalent to that to which… [they were] entitled under the provisions of the pre-2012 IFHP" [12]. On November 4, 2014, the Federal Government of Canada announced the introduction of temporary measures for IFHP. This new program reform was not a full reversal of the 2012 cuts, as ordered by the federal court, but it did restore some key health services [11].

Periods of healthcare exclusion or non-coverage existed under the new regime, resulting in the formulation of provincial government-led programs aimed to facilitate refugee access to healthcare [36]. Although, more provincial programs surfaced across the country, not all provided the same levels of coverage [12]. As a consequence, many refugees and refugee claimants continued to rely on the IFHP health coverage. The 2014 IFHP reforms restored certain key services for select categories of refugees and refugee claimants through a more complex system of health coverage. Six types of coverage are provided under this new temporary program [54]:

(1) Basic, supplementary (vision & dental), and prescription drug coverage.
(2) Basic and prescription drug coverage.
(3) Basic and PHPS prescription drug coverage.
(4) PHPS basic coverage and PHPS prescription drug coverage.
(5) Coverage for persons detained under the Immigration and Protection of Refugees Act.
(6) Coverage for the immigration medical examination.

The first four types of coverage provided varying levels of basic, supplementary and prescription drug coverage for select groups of refugees and refugee claimants [54, 55]. Type 1 applies to resettled refugees who are or were receiving monthly income support through Resettlement Assistance Programs, children less than 19 years of age, victims of human trafficking and certain people who are being resettled in Canada because of the Minister's humanitarian and compassionate considerations. Type 2 applies to pregnant women and rejected refugee claimants from countries to which the government cannot currently deport such as Iraq, Afghanistan, Congo, South Sudan, Gaza, Somalia and Syria. Type 2 coverage excludes supplementary vision and dental care. Type 3 applies to PSRs, active refugee claimants currently awaiting a claim decision and protected persons. Type 4 applies to ineligible refugee claimants, suspended refugee claimants and rejected refugee claimants who can be deported. Type 5 covers the costs of delivering healthcare services and products during the period an individual is detained by the Canadian Border Services Agency (CBSA). Type 6 provides immigration medical examination coverage for those who enter the country without permanent resident status and are provided with temporary or no immigration status.

Active, ineligible, suspended and rejected refugee claimants, PSRs, protected persons, claimants who are not children, pregnant women and refugees from a country to which deportation is banned do not have the same access to medications as before the 2012 retrenchments [55]. These groups may be covered only if their conditions pose a threat to public health or safety [55, 56]. Refugee claimants who are suspended, rejected or ineligible but allowed to apply for pre-removal risk assessment are provided with no care at all, except to prevent or treat conditions that pose a threat to public health or safety [55, 56]. Prior to the 2012 cuts, these individuals were provided with insurance until the date of deportation to ensure that their claim was indisputably invalid under Canadian refugee determination policies [56].

IFHP 2016—"Restoring Fairness"

On April 1st, 2016 the newly elected Liberal Government of Canada restored the IFHP to its previous coverage plan, as it was prior to the 2012 retrenchments, in which all refugees and claimants currently receive basic health coverage, prescription drug coverage and supplementary coverage, "until the beneficiary leaves Canada or becomes eligible for provincial or territorial health insurance" [57]. In a news release Minister John McCallum explains that, "Canadians from many walks of life, from premiers to front-line healthcare professionals to Canadians who privately sponsor refugees, spoke with one voice in rejecting the changes made to the IFHP in 2012. We have listened, and coverage will be restored" [58].

Discussion

As Canada moves forward with the new 2016 IFHP, it restores equitable healthcare for refugees and claimants. During Canada's 4 year-long IFHP reform experience, refugees and claimants were experiencing inequitable healthcare access because physicians refused to accept them as patients [28, 30, 33, 35]. Some of the most vulnerable individuals, such as pregnant women and children from select countries of origin, would receive care only if their condition posed a threat to public health in 2012. In 2014, pregnant women continued to experience limited access to healthcare services as they were not covered for vision and dental care. Privately sponsored refugees experienced further limitations to healthcare, as they would not be covered for prescription medications in 2014, unless their condition was a public health concern. The Government of Canada

resettled 25,000 Syrian refugees between November 2015 and February 29, 2016, including government-assisted and privately-sponsored refugees [59]. If the 2016 IFHP policy had not been implemented, thousands of Syrian refugees who were privately-sponsored by Canadian citizens would continue to receive limited healthcare access.

The reforms may have promoted delayed, ineffective management of acute and chronic illnesses among refugee populations, which leads to increased probabilities of disability and morbidity in the long-term. Another primary long-term repercussion that may follow the impact of the 4-year long reform is the confusion among healthcare providers and settlement workers as to who is currently eligible for comprehensive coverage. Although comprehensive healthcare coverage is now restored for all refugees and claimants, physicians and clinics may still be misinformed and continue to exclude refugees and claimants from accessing care. Denials to provide care for refugees and claimants by professionals was an issue before the 2012 IFHP reforms were introduced, and thus, this trend may still be occurring due to the complex changes over the past 4 years [28].

The authors recommend that the federal and provincial governments implement appropriate strategies to prevent persisting confusion among refugee care stakeholders. It is important to note that although the newly elected Liberal Government has formulated humanitarian health care policies that restore health equity among vulnerable refugee populations, the possibility that future governments may revert to older, ostensibly cost-saving models exists. As Loescher asserts, "the formulation of refugee policy involves a complex interplay of domestic and international factors at the policy-making level and illustrate[s] conflict between international humanitarian norms and the sometimes narrow self-interest calculations of sovereign nation-states," [60]. This research serves to inform current and future policy-makers of the social and human costs incurred by attempting to retrench health services for vulnerable populations to improve the economy.

Conclusion

Over the past 4 years, Canada's refugee policies have transformed from providing humanitarian relief and embracing nation-building notions to promoting precariousness and excluding refugees from rights, framing them as the other. In particular, the introduction of Bill C-31 in 2012 endorsed precarious status among refugee claimants and excluded them from the right to move, work or access healthcare. The 2012 cuts to the IFHP have produced further health inequities towards refugees with the provision of temporary and inadequate healthcare services, deemed "cruel and unusual" by the Federal Court [12]. Moreover, the formulation of the IFHP on the premise that refugees are 'bogus' and abusers of Canada's healthcare system stimulated the effect of othering a vulnerable group of people [49].

Refugee policies that restrict refugee and claimant access to healthcare violate human rights, propagate social exclusion and result in possible risk to the general population. Widespread human rights violation within countries of origin is one of the principal causes of forced and disruptive movements of people [1]. Disorderly movements of migrants, especially when they are irregular and unwanted, generate greater risk of further human rights violation in countries of transit and destination [61]. When this happens, management of migration becomes difficult and costly; it also entails heavy social and human costs. The rational for the 2012 reforms was primarily to cut costs and in Canada's case, transfer the cost from federal to provincial legislature. The severe social and human costs caused by the 2012 retrenchments to the IFHP, as outlined in this review, led to the formulation of the 2014 reforms. The 2014 reforms to the IFHP was not the panacea, as certain groups of refugee populations still experienced healthcare access inequity. However, the implementation of the 2014 IFHP reforms was one step in the right direction as it began to provide coverage and thus, allow more refugees and refugee claimants to access necessary care. As of April 1, 2016 the newly elected federal government in Canada has reinstated comprehensive coverage provided through the IFHP, as it was prior to the changes in 2012, "restoring fairness" and equity to refugee healthcare [58]. Canada's experience is an important lesson on the value of comprehensive health policies that include adequate healthcare from the moment refugees arrive in a country.

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References

1. United Nations High Commissioner of Refugees: World at War, Global Trends Forced Displacement 2014. Geneva, 2015. http://unhcr.org/556725e69.html. Accessed 12 Sept 2015.
2. United Nations: As Conflicts Multiply, World Community's Capacity to Respond to People Uprooted by Violence Being Tested in 'Unforeseen Ways', Third Committee Told | Meetings Coverage and Press Releases. 2012. http://www.un.org/press/en/2012/gashc4052.doc.htm. Accessed 12 July 2015.

3. United Nations High Commissioner for Refugees:War's Human Cost Global Trends. Geneva; 2014.
4. United Nations High Commissioner of Refugees. Asylum trends in industrialized countries. Oxford: Oxford University Press; 2003.
5. Dauvergne C. International human rights in Canadian immigration law—the case of the immigration and refugee board of Canada. Indiana J Glob Leg Stud. 2012;19(1):305–26.
6. United Nations High Commissioner for Refugees: Asylum Levels and Trends in Industrialized Countries, 2014. Geneva: 2014. http://www.unhcr.org/551128679.html. Accessed 12 Sept 2015.
7. Canada. Parliament. Library of Parliament:*Legislative Summary of Bill C-31:* An Act to Amend the Immigration and Refugee Protection Act (Report 41-1-C31-E) 2012. www.lop.parl.ga.ca/content/lop/LegislativeSummaries/41/1/c31-e.pdf. Accessed 12 July 2015.
8. Government of Canada, Citizenship and Immigration Canada: Information Sheet for Interim Federal Health Program Beneficiaries. 2012a. http://publications.gc.ca/collections/collection_2013/cic/Ci44-15-2012-eng.pdf. Accessed 12 Sept 2015.
9. Seeking Solutions Symposium: Access to health care for the uninsured in Canada. Toronto, 2013.
10. Government of Canada, Public Works and Government Services Canada: ARCHIVED—Canada Gazette—Order Respecting the Interim Federal Health Program, 2012. http://www.gazette.gc.ca/rp-pr/p2/2012/2012-04-25/html/si-tr26-eng.html. Accessed 12 July 2015.
11. Government of Canada, Citizenship and Immigration Canada: 2014 Annual Report to Parliament on Immigration. 2014. http://www.cic.gc.ca/English/resources/publications/annual-report-2014/index.asp#sec-2-2.Accessed 12 July 2015.
12. Canadian Doctors for Refugee Care v. Canada (Attorney General). 2014 FC 651.
13. United Nations High Commissioner for Refugees: Convention and Protocol Relating to the Status of Refugees. Geneva; 2010.
14. Immigration and Refugee Protection Act [Canada]. S. C. 2001, c.27, 77.
15. Casswell DG. Singh v. Minister of employment and immigration. Alta L Rev. 1985;24:356.
16. Manjikian L. Refugee narratives in montreal: negotiating everyday social exclusion and inclusion. Montreal: McGill University; 2013. p. 1–333.
17. Bhuyan R, Osborne B, Sajedeh Z, Tarshis S. Unprotected, unrecognized: Canadian immigration policy and violence against women, 2008–2013. Toronto: Migrant Mothers Project; 2014.
18. Jackson S. 'Citizenship Theatre': refugee claimants, security, and performing citizenship at the immigration and refugee board. Hamilton: McMaster University; 2013. p. 1–25.
19. World Health Organization: News Release. Worldwide action needed to address hidden crisis of violence against women and girls. 2014. http://www.who.int/mediacentre/news/releases/2014/violence-women-girls/en/. Accessed 12 Sept 2015.
20. METRAC, Barbara Schlifer Clinic, & LE AF:Bill C-31 will re-victimize women refugees and their children [Press release]. 2012. http://schliferclinic.com/advocacy-and-social-change/legal-reform/immigration/. Accessed 12 Sept 2015.
21. Government of Canada, Citizenship and Immigration Canada:The Refugee System in Canada. 2015http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp. Accessed 12 Sept 2015.
22. Goldring L, Bernstein C, Bernhard J. Institutionalizing precarious migratory status in Canada. Citizsh Stud. 2009;13(3):239–65.
23. Cleveland J, Rousseau C. Mental health impact of detention and temporary status for refugee claimants under Bill C-31. Can Med Assoc J. 2012;184(15):1663–4.
24. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a systematic review. Lancet. 2005;365(9467):1309–14.
25. Ryan DA, Kelly FE, Kelly BD. Mental health among persons awaiting an asylum outcome in Western countries. Int J Ment Health. 2009;38(3):88–111.
26. Besier M. The health of immigrants and refugees in Canada. Can J Public Health. 2005;96(2):530–44.
27. McKeary M, Newbold B. Barriers to care: The challenges for Canadian refugees and their health care providers. J Refugee Stud. 2010;23(4):523–45. doi:10.1093/jrs/feq038.
28. Miedema B, Hamilton R, Easley J. Climbing the walls. Can Fam Phys. 2008;54(3):335–6.
29. Barnes S. The real cost of cutting the interim federal health program. Toronto: Wellesley Institute; 2013. p. 1–19.
30. Sheikh H, Rashid M, Berger P, Hulme J. Refugee health providing the best possible care in the face of crippling cuts. Can Fam Phys. 2013;59(6):605–6.
31. Minister of Justice: Consolidated federal laws of Canada, Order Respecting the Interim Federal Health Program, 2012. http://laws-lois.justice.gc.ca/eng/regulations/SI-2012-26/page-1.html. Accessed 12 Sept 2015.
32. Morrison J: Cuts to supplemental health benefits for refugees: Expanding the understanding of patient-centred care. Canadian Pharmacists Journal/Revue Des Pharmaciens Du Canada 2012; 145(6), 285–286. http://www.swslhd.nsw.gov.au/refugee/pdf/NSW_REFUGEE_STARTTS.pdf. Accessed 12 Sept 2015.
33. Raza D, Rashid M, Redwood-Campbell L, Rouleau K, Berger P. A moral duty why Canada's cuts to refugee health must be reversed. Can Fam Phys. 2012;58(7):728–9.
34. General Issues Committee: Report 12-014. Hamilton, ON: City of Hamilton; 2012. http://www2.hamilton.ca/NR/rdonlyres/3C1C94E8-0A93-47DD-98A7-86755B14BA05/0/May16EDRMS_n311232_v1_014__Minutes__May_16_.pdf. Accessed 12 Sept 2015.
35. Eggertson L. Doctors promise protests along with court challenge to refugee health cuts. Can Med Assoc J. 2013;185(7):E275–6.
36. Government of Ontario, MOHLTC: Newsroom: Ontario Temporary Health Program 2013. http://news.ontario.ca/mohltc/en/2013/12/ontario-temporary-health-program.html.
37. Benzie, R: Health Minister Eric Hoskins says Ontario is sending Ottawa the bill for the $2 million the province will spend this year on basic medical services for refugees. The Toronto Star 2014, July 23. http://www.thestar.com/news/queenspark/2014/07/23/ontario_will_bill_ottawa_for_refugee_health_costs.html.
38. Wahoush EO. Equitable health-care access: the experiences of refugee and refugee claimant mothers with an ill preschooler. Can J Nurs Res. 2009;41(3):186–206.
39. Newbold B. Linking immigrant settlement, health, housing and homelessness in Canada. Canadian Issues/ThèmesCanadiens (Newcomer's experiences of housing and homelessness in Canada). Montréal: Association for Canadian Studies; 2010. p. 8–15.
40. Berman H, Girón ERI, Marroquín AP. A narrative study of refugee women who have experienced violence in the context of war. Can j Nurs Res. 2009;41(1):144–65.
41. Olsen C, El-Bialy R, Mckelvie M, Rauman P, Brunger F. "Other" troubles: deconstructing perceptions and changing responses to refugees in Canada. J Immigr Minor Health. 2014;. doi:10.1007/s10903-014-9983-0.
42. Greenaway C, Sandoe A, Vissandjee B, Kitai I, Gruner D, Wobeser W, Schwartzman K. Tuberculosis: evidence review for newly arriving immigrants and refugees. CMAJ. 2011;183(112):E939–51. doi:10.1503/cmaj.090302.
43. Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, Tugwell P. Evidence-based clinical guidelines for immigrants and refugees. CMAJ. 2011;183(12):E824–925. doi:10.1503/cmaj.090313.
44. Rossi C, Shrier I, Marshall L, Cnossen S, Schwartzman K, Klein MB, Greenaway C. Seroprevalence of chronic hepatitis B virus

infection and prior immunity in immigrants and refaugees: a systematic review and meta-analysis. PLoS One. 2012;7(9):e44611. doi:10.1371/journal.pone.0044611.
45. Zencovich M, Kennedy K, MacPherson DW, Gushulak BD. Immigration medical screening and HIV infection in Canada. Int J STD AIDS. 2006;17(12):813–6. doi:10.1258/095646206779307469.
46. Fowler N. Providing primary health care to immigrants and refugees: the North Hamilton experience. CMAJ. 1998;159:388–91.
47. Gagnon AJ, Dougherty G, Wahoush O, Saucier JF, Dennis CL, Stanger E. Stewart DE (2013) International migration to Canada: The post-birth health of mothers and infants by immigration class. Soc Sci Med. 2013;76:197–207. doi:10.1016/j.socscimed.2012.11.001.
48. Redditt VJ, Janakiram P, Graziano D, Rashid M. Health status of newly arrived refugees in Toronto, Ont Part 1: infectious diseases. Can Fam Phys. 2015;61(7):e303–9.
49. Government of Canada, Citizenship and Immigration Canada: Canada News Centre-Archived–Reform of the Interim Federal Health Program ensures fairness, protects public health and safety [News Releases]. 2012.http://news.gc.ca/web/article-en.do?nid=670949. Accessed 12 Sept 2015.
50. Basok T. Refugee policy: globalization, radical challenge, or state control? Stud Political Econ. 1996;50:133–66.
51. Evans A, Caudarella A, Ratnapalan S, Chan K. The cost and impact of the Interim Federal Health Program cuts on child refugees in Canada. PLoS One. 2014;9(5):e96902. doi:10.1371/journal.pone.0096902.
52. Redditt VJ, Graziano D, Janakiram P, Rashid M. Health status of newly arrived refugees in Toronto, Ont Part 2: chronic diseases. Can Fam Phys. 2015;61(7):e310–5.
53. Sanders C: Province steps up for refugees. 2012. http://www.winnipegfreepress.com/local/province-steps-up-for-refugees-169590316.html. Accessed 12 Sept 2015.
54. Government of Canada, Citizenship and Immigration Canada: Interim Federal Health Program Policy. 2014. http://www.cic.gc.ca/english/department/laws-policy/ifhp.asp.
55. Government of Canada, Citizenship and Immigration Canada: Interim Federal Health Program: Summary of Benefits. 2015. http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp. Accessed 12 Sept 2015.
56. Goel R: OPINION: Federal reversal of refugee health cuts still leaves many uncovered. 2014. http://healthydebate.ca/opinions/reversal-of-refugee-health-cuts. Accessed 12 Sept 2015.
57. Government of Canada, IRCC: Guide 5568: Applicaton for the Interim Federal Health Program Coverage. 2016. http://www.cic.gc.ca/english/information/applications/guides/5568ETOC.asp#5568E2. Accessed 12 June 2016.
58. Government of Canada, Citizenship and Immigration Canada: Restoring Fairness to the Interim Federal Health Program [New Releases]. 2016. http://news.gc.ca/web/article-en.do?mthd=tp&crtr.page=1&nid=1034619&crtr.tp1D=1. Accessed 15 Jan 2016.
59. Government of Canada, Immigration, Refugee and Citizenship, Canada [IRCC]:# WelcomeRefugees: Canada Resesttles Styrian Refugees. 2016. http://www.cic.gc.ca/english/refugees/welcome/. Accessed 12 June 2016.
60. Loescher G. Introduction. In: Loescher G, Monahan L, editors. Refugees and international relations. New York: Oxford University Press; 1989. p. 1–33.
61. Ghosh B. Managing migration: towards the missing regime. Chapter 5 in migration without borders: essays on the free movement of people, edited by Antoine Pécoud and Paul de Guchteneire. Paris: UNESCO Publishing; 2007. p. 97–118.