MIXED RESEARCH

Impacts of the Interim Federal Health Program reforms: A stakeholder analysis of barriers to health care access and provision for refugees

Valentina Antonipillai, MSc,[1,2] Andrea Baumann, PhD,[2,3] Andrea Hunter, MD,[4] Olive Wahoush, PhD,[2,3] Timothy O'Shea, MD[5]

ABSTRACT

BACKGROUND: Changes to the Interim Federal Health Program (IFHP) in 2012 reduced health care access for refugees and refugee claimants, generating concerns among key stakeholders. In 2014, a new IFHP temporarily reinstated access to some health services; however, little is known about these changes, and more information is needed to map the IFHP's impact.

OBJECTIVE: This study explores barriers occurring during the time period of the IFHP reforms to health care access and provision for refugees.

METHODS: A stakeholder analysis, using 23 semi-structured interviews, was conducted to obtain insight into stakeholder perceptions of the 2014 reforms, as well as stakeholders' position and their influence to assess the acceptability of the IFHP changes.

RESULTS: The majority of stakeholders expressed concerns about the 2014 IFHP changes as a result of the continuing barriers posed by the 2012 retrenchments and the emergence of new barriers to health care access and provision for refugees. Key barriers identified included lack of communication and awareness, lack of continuity and comprehensive care, negative political discourse and increased costs. A few stakeholders supported the reforms as they represented some, but limited, access to health care.

CONCLUSION: Overall, the reforms to the IFHP in 2014 generated barriers to health care access and provision that contributed to confusion among stakeholders, the transfer of refugee health responsibility to provincial authorities and the likelihood of increased health outcome disparities, as refugees and refugee claimants chose to delay seeking health care. The study recommends that policy-makers engage with refugee health stakeholders to formulate a policy that improves health care provision and access for refugee populations.

KEY WORDS: Refugees; health policy; Interim Federal Health Program; stakeholder analysis

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2017;108(4):e435–e441
doi: 10.17269/CJPH.108.5553

The United Nations High Commissioner for Refugees reports that there are 65.3 million forcibly displaced migrants worldwide.[1] Of these migrants, 21.3 million are refugees seeking asylum from the endemic violence and human rights violations in their homelands.[1] In 2015, Canada opened its doors to 32 000 refugees, including government-assisted refugees (GARs), privately sponsored refugees (PSRs) and refugee claimants, all of whom are eligible to receive health care coverage under Canada's Interim Federal Health Program (IFHP) policy.[2] Prior to 2012, comprehensive health care coverage was available under the IFHP for GARs, PSRs, protected persons, refugee claimants and refused refugee claimants with negative decisions under appeal or review, or those awaiting deportation.[3] Government-funded health care insurance included basic health care, supplementary health care and drug coverage, to promote equitable treatment of vulnerable individuals, regardless of claim approval or country of origin.[3]

In 2012, changes to Canada's refugee health policy were introduced through the IFHP, significantly reducing health care coverage for certain refugee populations and resulting in the loss of insured medical care and hospital service provisions for many who had previously been covered.[4–6] Concerns for refugees and claimants, voiced by Canadian health care organizations and professionals, prompted the Federal Court of Canada to reassess the impact of the IFHP changes.[7,8] Within one month of the introduction of the 2012 IFHP reforms, eight national health associations expressed their apprehensions and opposition to the changes.[7,9,10] On February 25, 2013, a legal challenge launched by the Canadian Doctors for Refugee Care with the Canadian Association for Refugee Lawyers was successfully appealed to the Federal Court of Canada.[11] The court deemed that the IFHP reforms violated section 12 of the Canadian Charter of Rights, constituting "cruel and unusual treatment" of vulnerable refugee populations.[12] Furthermore, the court ruled that the 2012 IFHP cuts were "of no

Author Affiliations

1. Health Policy PhD Program, McMaster University, Hamilton, ON
2. Global Health, McMaster University, Hamilton, ON
3. School of Nursing, McMaster University, Hamilton, ON
4. Paediatrics, McMaster University, Hamilton, ON
5. School of Medicine, McMaster University, Hamilton, ON

Correspondence: Valentina Antonipillai, Health Policy PhD Program, McMaster University, Department of Health Research Methods, Evidence and Impact, 1280 Main Street West, Hamilton, ON L8S 4L8, Tel: 905-525-9140, E-mail: antoniv@mcmaster.ca

Conflict of Interest: None to declare.

© 2017 Canadian Public Health Association or its licensor.

Table 1. Types of coverage associated with the 2014 reforms to the IFHP

2014 Interim Federal Health Program reforms		
Type of coverage	**Population receiving coverage**	**What does this mean?**
Type 1: Basic, supplementary, and prescription drug coverage	• Government assisted refugees: Resettled refugees who are or were receiving monthly income support through the Resettlement Assistance Program • Children (below 19 years of age) • Victims of human trafficking • Individuals who resettle in Canada under the Citizenship and Immigration Minister's humanitarian and compassionate considerations	All health coverage benefits provided
Type 2: Basic and prescription drug coverage	• Pregnant women • Rejected refugee claimants from non-deportable countries (Iraq, Afghanistan, Congo, South Sudan, Gaza, Somalia and Syria)	Lack of supplementary coverage (vision and dental care)
Type 3: Basic and Public Health and Public Safety (PHPS) prescription drug coverage	• Privately sponsored refugees • Active refugee claimants currently awaiting a claim decision • Protected persons	Lack of supplementary coverage and limited drug coverage
Type 4: PHPS basic coverage and PHPS prescription drug coverage	• Ineligible refugee claimants • Suspended refugee claimants • Rejected refugee claimants who can be deported to country of origin • Refugee claimants eligible to apply for pre-removal risk assessment	Lack of supplementary coverage, limited drug coverage and limited basic coverage
Type 5: Coverage for persons detained under the *Immigration and Refugee Protection Act*	• Individual detained by the Canadian Border Services Agency	Not specified
Type 6: Coverage for the immigration medical examination	• All individuals who enter the country without permanent resident status and are provided with temporary or no immigration status	Only immigration medical examination is covered

force or effect", encouraging the implementation of "health insurance coverage that is equivalent to that to which… [refugees 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 the IFHP".[13] 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 to select categories of refugee populations through a more complex system of health coverage, in which six types of coverage, instead of three, were provided[13] (see Table 1). Moreover, health care coverage gaps continued to exist for refugees and refugee claimants under the new program, resulting in the formulation of provincial government-led programs and clinics for newcomers aimed at bridging the health care access gap for refugees.[14,15]

This study addresses the gap in the literature regarding the impact of the 2014 IFHP reforms on health care access and provision for refugees and refugee claimants by examining stakeholder views. Stakeholders possess critical insight that brings information to the deliberation process of policy, aiding policy-makers to make decisions that are more likely to avoid unintended consequences and to fit into existing contexts. As policy-making is an information-intensive process, stakeholders who possess tacit knowledge of the current situation possess value.[16] Furthermore, policy effectiveness can be judged using several methods, one of which is to examine the acceptability of a policy by stakeholders.[17] The impact of refugee health policy is of wide significance, given the increasing volume of displaced people seeking refuge in Canada and around the world.[1] Examining the IFHP reforms is important for refugee-serving providers, organizations and policy-makers, as the study contextualizes the problem of introducing reforms to refugee health policy and reveals the subsequent complexities involved in accessing and providing health care for refugees and refugee claimants.

METHODS

Semi-structured key informant interviews were conducted with 23 stakeholders. Using a stakeholder identification framework,[18] four stakeholder groups were identified: policy-makers and government officials (PG), professionals and practitioners in the field of refugee health (PP), refugee-serving civil society organizations (CSO) and refugees and refugee claimants (RRC). Policy-makers and government officials were represented at the national, provincial and local levels. Refugees and refugee claimants were included if they arrived in Canada between 2012 and 2015, having experienced the IFHP reforms. This stakeholder category included Convention refugees,[19] refugee claimants, as well as claimants who were refused or were ineligible for refugee status within the time period. The RRC participants were from designated* and non-designated countries of origin, spanning three continents: Africa, Asia and Europe (see Appendix A).

Ethics approval was obtained from the Hamilton Integrated Research Ethics Board. Purposive sampling methodology was used to recruit key stakeholders in consultation with experts in the field of refugee health and policy. Stakeholders were sampled if they were affected by or able to influence the IFHP policy process.[20] Interviews were conducted between May 2015 and August 2015. As nearly 50% of refugees are received by and resettled in Ontario,[21] the majority of stakeholders were interviewed across various cities within the province. Interview guides were constructed in consultation with experts in refugee health and qualitative research at McMaster University. The interview style and probes were developed to

* Designated countries of origin (DCOs) are countries deemed by the Federal Government to be places that do not normally produce refugees and that respect human rights and offer state protection. Refugees from DCOs are subjected to shorter claim processing timelines, prohibited from appealing failed refugee claims and, if their claim for refugee status is denied, are unable to reapply invoking humanitarian and compassionate grounds for up to one year.

Non-designated countries of origin are countries that are not deemed safe for return by refugees.

promote a conversation with stakeholders during the interview, maintaining a "conversation with a purpose" style using an open-ended approach to gather data.[22] Interviews lasted 20–90 minutes and were recorded. All 23 digital recordings were securely stored and transcribed by the primary investigator (VA).

A stakeholder analysis was conducted by systematically gathering and analyzing qualitative data to obtain insight into stakeholder positions, interests and influences regarding the 2014 IFHP reforms. To understand stakeholder experiences as a result of the policy reforms, a phenomenological approach was employed to analyze stakeholder perceptions.[23,24] Themes were abstracted using a constant comparative approach with QSR International NVivo 10. Positions of stakeholders and barriers to providing and accessing health care for refugee populations emerged. The coding process incorporated both a priori codes based on the literature and inductive codes derived from the data. Specifically, data analysis was guided by a modified version of the Health Care Access Barrier model, including cognitive, structural and financial barriers,[25] with the addition of socio-political barriers (see Figure 1).[26] Moreover, a stakeholder map was generated to analyze the relationship between stakeholders' positions on the IFHP 2014 reforms and their ability to influence policy.[27] The quality of the results was confirmed by verifying rigour through triangulation, thick description and NVivo 10 audit trial.[28]

RESULTS

Several common themes emerged from the perceptions of refugee health stakeholders regarding barriers to accessing and providing health care for refugee populations during the 2014 IFHP reforms. Only four barriers to health care access were common across all four stakeholder groups: lack of awareness and miscommunication, lack of continuous and comprehensive care, negative political discourse and increased costs of care.

Cognitive barrier: Lack of awareness and miscommunication

A lack of awareness and miscommunication about the IFHP was a barrier to the provision of health care for refugees and refugee claimants. The implementation of the new Temporary Measures for the IFH Program on November 4, 2014, involved no efforts by the federal government to facilitate awareness except by listing coverage details on the official website. Lack of efforts to implement complex plans resulted in persisting confusion initiated by the 2012 IFHP retrenchments as to refugee patient eligibility for services. According to a stakeholder,

> *"The government is doing the base minimum as opposed to doing the right thing. The implementation has been terrible because there has not been any significant communication that is actually going to the providers, or to the refugee lawyers, or to the refugee-serving organizations, or to the refugees themselves, because confusion means that less people will know that they are eligible and confusion will mean that less providers will know what is eligible and therefore, the end result will be that refugee claimants will not have access."* (PG2)

The confusion and complexity of coverage plans deterred providers from offering services covered under the program. One physician summarized the impact, stating,

> *"Physicians who accept IFH a year ago still are not accepting it now and part of that is although there is increased scope of insurance coverage many people just don't understand it… [the coverage plans] are so complicated, so people often get turned away in private offices, or be asked to sign forms assuming responsibility for financial costs… I think for those who understand it, it's lovely to know that children now have the same coverage that they had in the past, but if you survey a lot of health care workers I'd be surprised if they actually understood that."* (PP2)

Moreover, a lack of IFHP awareness exists among refugees and claimants. According to a refugee-serving provider,

> *"People are not aware of what's going on especially with so many changes… I cannot name you one client out of these 300 or 400 files that came here and knew that [the IFHP] is their health coverage."* (PP6)

The lack of awareness limited refugees' ability to understand or question the circumstances of their care. As one refugee stakeholder indicated, *"We don't know why we pay for services now, because first everything is covered and then in 2012, after then, everything was paying, it was the system."* (RRC2)

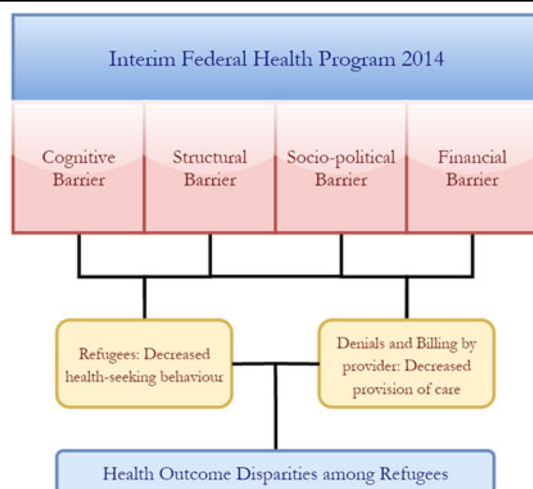

Figure 1. Health care access and provision barriers

Structural barrier: Lack of continuous and comprehensive care

Most participants expressed opposition to the reforms because there was a lack of continuous and comprehensive care accessible to refugees and refugee claimants. Refused refugee claimants and people applying for pre-removal risk assessment did not have access to health care coverage.[13] A key stakeholder relates an additional example of the impact of discontinued coverage:

> *"Some people have trouble accessing [the IFHP] because they fall into sort of the gray area between the application that they are going to make as a refugee claimant and their actual arrival on Canadian soil and so we have seen … one gentleman who was in the hospital for a week with no coverage and he didn't have coverage because he never made it to his initial citizenship and*

immigration interview and so he was falling into that gray area. We've had other people like that but not so severe as that one gentleman who came up with a bill for $20,000." (PP5)

Furthermore, privately sponsored refugees also experienced limited health care coverage upon arrival in Canada. They are refugees recognized by the United Nations High Commission for Refugees,[29] yet they only received basic health care coverage in Canada. This included physician and hospital visits as well as diagnostic and laboratory tests.[13] If they were in need of prescription medication or supplementary care, they were only covered for these services if their condition posed a threat to public health or public safety. The lack of comprehensive care was expressed by the majority of stakeholders as a barrier to appropriate access:

"[Those affected by the cuts] include people from such places as Syria where there is no doubt that people are in need of protection, and even those people are not getting medications covered. So if somebody is coming from Syria, coming as a privately sponsored refugee and they have cancer, it's too bad for you, your cancer medication is not covered." (PP3)

Socio-political barrier: Political discourse

Many stakeholders recognized that "Canada is a nation of immigrants and refugees", yet throughout the political discourse, actors inappropriately referred to refugee claimants as queue jumpers. Interviewed stakeholders explained the impacts of the negative political discourse on accessing health care:

"There are two different lines – it's [the discourse] conflating immigration policy with refugee policy and rules on purpose and… [it] feeds that kind of mean spiritedness that wants to protect Canada from some, you know, infusions of people breaking the rules and so they're trying to make it sound like refugees are rule breakers as opposed to legitimate immigrants that wait their turn and come when asked." (PP3)

"The negative discourse results in social stigma around all refugees and claimants labeling them as "bogus" without consideration of those that are genuine in need of humanitarian aid. Stigma discourages refugees and claimants from seeking help within the Canadian health care system." (PG4)

"It's a program that we should be proud of and instead of that, the political discourse… is trying to tarnish it, as though people are misusing the program, and that they're not entitled to it, and that they're "bogus" and "failed". All of these negative words make people feel embarrassed to seek help so, that does affect access." (PG2)

Financial barrier: Increased costs

Stakeholders perceived the IFHP reforms over the past four years as having increased provincial spending. According to policy-makers: *"As a provincial government, we looked at [all of the IFHP reforms] as a setback in health care"* (PG5); *"Ontario is picking up the costs so this is yet another insidious form of downloading."* (PG4);

"The reforms have led to some refugees being denied care even when they are eligible… so the provinces have to pick up the health care costs of people turning up uninsured in ERs in poorer health than they could be if they actually received their services earlier." (PG3)

Moreover, stakeholders reported that barriers to access included the financial cost of care placed on refugees and claimants:

"We just saw a [refugee] woman who came 7 months' pregnant. She came with malaria and was in the hospital for more than a week and because she went to the emergency they put her in the ICU and with all the specialists; they were sending her bills. Her bill is more or less $30,000 and she doesn't have a way to pay." (CSO2)

Additionally, as a result of the lack of awareness among care providers and refugees regarding the IFHP reforms, health care organizations were spending more:

"What community health centres have been reporting is that they are having to use their small amount of funding for refugees and refugee claimants who may actually be able to access IFH." (PG3)

Stakeholder views

The majority of policy-makers expressed views opposing the 2014 changes to the IFHP ($n = 4$), indicating that the refugee health policy changes did not ameliorate the devastating impact of the 2012 retrenchments experienced by refugee populations and, instead, exacerbated the problem of access and provision of health care. Many of the CSO and PP members held mixed views ($n = 8$). Participants who held mixed views supported the restoration of some services in 2014 but opposed the remaining limitations to health care under the IFHP. The majority of refugees and refugee claimants ($n = 4$) supported the 2014 IFHP reforms because the insurance plan offered in 2014 provided more coverage than their former plans, either in their country of origin or the 2012 plan previously provided under the IFHP in Canada:

"If it covers some health care then, of course, I support it. Nobody wants to pay so much money when they're sick. They have to pay the bills, the rent and then their medical bills." (RRC2)

Altogether, eight stakeholders expressed opposing views to the 2014 reforms, on the basis that the changes did not alleviate problems posed by the 2012 retrenchments; ten held mixed views, supporting the reinstatement of some services in 2014 but opposing the remaining cutbacks; four supported the 2014 reforms; and one did not comment. The stakeholder map (Figure 2) displays participant positions and their ability to influence the policy. The map categorizes participants as low-priority, advocate, antagonistic or problematic stakeholders. Low-priority individuals support the policy but cannot influence policy change; advocates support the policy and have a high influence over the policy process; problematic stakeholders oppose the policy but do not have enough influence over it; and antagonistic stakeholders oppose the policy and retain high influence to change it.[27] The majority of stakeholders were categorized as antagonistic or problematic, which reflects their opposing and mixed views regarding the 2014 changes to the IFHP and reveals a need for stakeholder engagement before future changes to the IFHP are implemented. Most stakeholders expressed opposition or mixed views towards the reforms in 2014 as a result of the aforementioned barriers to accessing and providing health care.

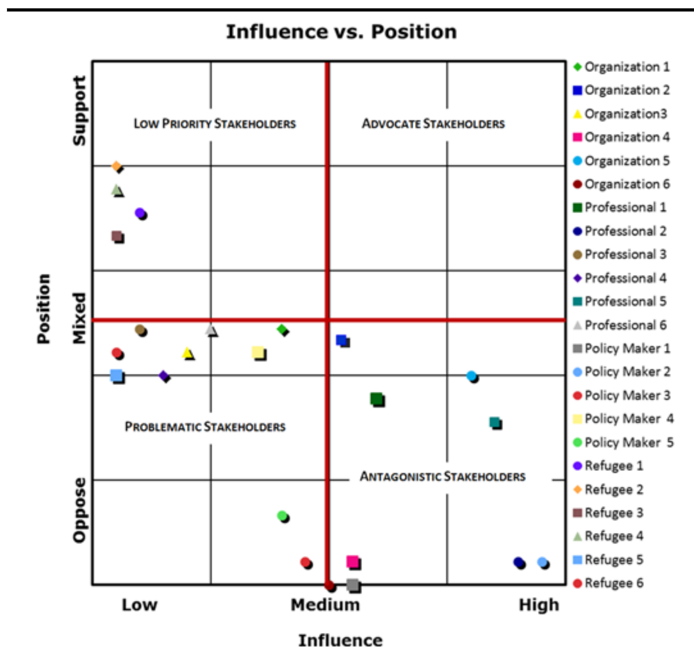

Figure 2. Stakeholder map: Influence vs. position

DISCUSSION

Principal findings

The majority of participants expressed opposing and mixed views regarding the 2014 IFHP reforms and were subsequently categorized as problematic and antagonistic stakeholders, because they believed that the 2014 changes did not provide comprehensive coverage for refugees. Instead, stakeholders conveyed the impression that with respect to the 2012 retrenchments these changes both created and contributed to persisting barriers to health care access and provision for refugees. This is a significant finding given that a wide spectrum of views were included and only a small number of respondents represented refugee advocates. Instead of promoting equitable health outcomes for a vulnerable group of refugees, the 2014 IFHP reforms continued to retrench coverage, which prevented refugees and claimants from having access to continuous and comprehensive health care. Moreover, there was a lack of awareness and miscommunication regarding the 2014 IFHP reform content, eligibility criteria and coverage levels, which contributed to the immense confusion among stakeholders. The resulting confusion led some providers to refuse care to refugees or ask refugees to assume financial costs for their health care, despite their inability to afford them. As a result, refugee populations would delay seeking health care until an emergency, at which point the province and health care organizations would pay the costs. The negative political discourse also contributed to stigma and tensions within communities that prevented refugees from accessing health care.

Strengths and limitations

The diverse array of perceptions retrieved from a variety of refugee health stakeholders is a notable strength of the study. The key insights obtained from stakeholder perceptions have contributed to understanding the IFHP reform landscape in 2014 for incoming refugee populations and may explain long-term consequences faced by these individuals after resettlement in Canada. The stakeholder analysis provides point-in-time snapshots related to the IFHP 2014 reforms in which stakeholder positions and influence are subject to change. Therefore, a limitation of the study is that the data obtained are valid only for the time during which they were collected.[30]

Implications

In contrast with non-public actors, such as professionals and organizations that administered the changes to refugee health policy, “institutional contours of the Canada Polity have led to a situation in which publicly accountable actors tend to have less of a national reach”.[31] The government’s minimal effort to coordinate and consult with key stakeholders, including consumers (refugees) and administrators, led to one of Canada’s main challenges regarding the implementation of effective refugee health care reform. The paucity of stakeholder engagement in formulating and implementing the IFHP reforms in 2012 and 2014 has resulted in unintended consequences. Moreover, limited collaboration between federal and provincial governments over the past four years has contributed to the development of a fragmented system whereby provincial-led coverage programs and clinics for newcomers attempted to bridge the gap.[15]

In response to the confusion created by the reforms and the concerned voices of many stakeholders, the newly elected Liberal Government of Canada restored comprehensive health care coverage for all refugees and claimants through the IFHP on April 1, 2016.[32] In a press release, the government acknowledged the barriers associated with the IFHP retrenchments in 2012 and asserted that the IFHP restoration in 2016 “will improve the health outcomes of refugees and asylum claimants, while also protecting public health for all Canadians. Restoring the Interim Federal Health Program will also provide financial relief to Canadians who privately sponsor refugees, reduce the administrative burden faced by health-care professionals serving refugees, and ease health-care funding pressure on provincial and territorial governments”.[33] To advance these objectives and to avoid the unintended consequences resulting from reforming the IFHP in the future, a commitment to data collection, information sharing and evidence-informed policy-making with the inclusion of stakeholder dialogues is necessary. Without this systematic and comprehensive approach, reforming the IFHP will result in social and human costs, such as those revealed by stakeholders in this study. Future research is needed to assess the effectiveness of the IFHP in achieving equitable health outcomes for refugee populations. Efforts that are aimed at integrating insights from relevant research could both facilitate policy change and, ultimately, improve health outcomes for vulnerable refugee populations.

CONCLUSION

This study reveals key stakeholders’ perception that the 2014 changes to refugee health policy exacerbated existing barriers and generated additional barriers to access and provision of health care, barriers that deter refugees and claimants from seeking health care and consequently lead to health outcome disparities for a vulnerable population. In Canada, policy-makers and government officials, civil society organizations, and professionals and practitioners expressed opposition to the 2014 IFHP reforms, reporting that the lack of communication and awareness about the reforms created confusion, which contributed to the protraction of the decreased provision of care for refugees initiated by the 2012 retrenchments. The 2012 and

2014 IFHP changes have led to the deterioration of health for some refugees, as the reforms prevented access to comprehensive and continuous care. Stakeholders emphasized that the negative political discourse and increased financial burden prevented refugees from accessing health care. Overall, the reforms to the IFHP in 2014 and 2012 transferred refugee health costs and responsibility from federal to provincial authorities, resulting in bureaucratic strains, inefficiencies and overburdened administration, which contributed to confusion. Canada's experience may provide other nations considering similar regulations with insights into the impacts of retrenching refugee health policy. Given the global refugee crisis, Canada's newly elected government has renewed its focus on welcoming refugees and in 2016 reinstated the coverage provided through the pre-2012 IFHP. This was a crucial step forward by the nation to remedy some of the consequences endured by refugee populations, to reverse some of the costs incurred by Canadian provinces and to provide an equitable response to refugees seeking asylum during these troubled times.

APPENDIX A

Table A1. Policy-maker and government official stakeholders

Stakeholder	Description	Influence	Position
Policy-maker 1	Works at the policy, research and consulting level regarding immigration and refugee policy; former government official	Moderate	Opposed
Policy-maker 2	Government official involved in health at the federal level	High	Opposed
Policy-maker 3	Works at the policy and research level regarding refugee and refugee claimant immigration and health policy	Moderate-low	Opposed
Policy-maker 4	Works at the policy and public awareness level of immigrant and refugee policy	Low	Not disclosed
Policy-maker 5	Government official formerly involved in immigration and refugee policy at the provincial level	Moderate-low	Opposed

Table A2. Civil society organization stakeholders

Stakeholder	Description	Influence	Position
Organization 1	Provides leadership programs, training and employment opportunities for refugees and claimants	Moderate	Mixed
Organization 2	Provides settlement services and primary health care for refugees and refugee claimants	Moderate	Mixed
Organization 3	Provides legal services in counselling, immigration, refugee and family law, and aid for refugees and refugee claimants	Low	Mixed
Organization 4	Provides primary health care, employment and housing services for refugees and refugee claimants	Moderate	Opposed
Organization 5	Provides legal services for refugees and refugee claimants, and public legal education and law reform work	High	Mixed
Organization 6	Provides settlement and integration services for refugee claimants	Moderate	Opposed

Table A3. Professional and practitioner stakeholders

Stakeholder	Description	Influence	Position
Professional 1	Provides health care to refugees and refugee claimants	Moderate	Mixed
Professional 2	Provides health care to refugees and refugee claimants	High	Opposed
Professional 3	Provides settlement services to refugees and refugee claimants	Low	Mixed
Professional 4	Provides legal services to refugees and refugee claimants	Low	Opposed
Professional 5	Provides legal services to refugees and refugee claimants	High-moderate	Mixed
Professional 6	Provides settlement services to refugees and refugee claimants	Low	Mixed

Table A4. Refugee and refugee claimant stakeholder characteristics

Stakeholder	Description	Influence	Position
Refugee 1	Refugee since February 2014 from designated country of origin*	Low	Supportive
Refugee 2	Refugee claimant since 2011 from non-designated country of origin†	Low	Supportive
Refugee 3	Refugee claimant since 2009 from designated country of origin	Low	Supportive
Refugee 4	Refugee claimant since 2012 and current Convention refugee‡ from non-designated country of origin	Low	Mixed
Refugee 5	Failed refugee claimant in 2012, applied for humanitarian and compassionate consideration. Convention refugee since 2015 May from designated country of origin	Low	Mixed
Refugee 6	Convention refugee since December 2013 from designated country of origin	Low	Supportive

* Designated countries of origin are countries deemed by the Federal Government to be places that do not normally produce refugees, and that respect human rights and offer state protection. Refugees from DCOs are subjected to shorter claim processing timelines, prohibited from appealing failed refugee claims and, if their claim for refugee status is denied, cannot reapply invoking humanitarian and compassionate grounds for up to one year.

† Non-designated countries of origin include countries that are not deemed safe for return by refugees.

‡ Convention refugees are persons "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, due to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country where he/she normally lives, is unable or, due to such fear, is unwilling to return to it."[19]

REFERENCES

1. United Nations High Commissioner for Refugees [UNHCR]. *Global Trends: Forced Displacement in 2015*. Geneva, Switzerland: UNHCR, 2016. Available at: http://www.unhcr.org/statistics/unhcrstats/576408cd7/unhcr-global-trends-2015.html (Accessed February 2017).
2. Immigration Refugees and Citizenship Canada [IRCC]. *Interim Federal Health Program Policy*. 2016. Available at: http://www.cic.gc.ca/english/department/laws-policy/ifhp.asp (Accessed May 2016).
3. Citizenship and Immigration Canada [CIC]. *Interim Federal Health Program: Information Handbook for Health-Care-Providers*. Edmonton, AB: FAS Benefit Administration Ltd., 2006.
4. CIC. *Information Sheet for Interim Federal Health Program Beneficiaries*. 2012. Available at: http://publications.gc.ca/collections/collection_2013/cic/Ci44-15-2012-eng.pdf (Accessed January 15, 2016).
5. Government of Canada. *Public Works and Government Services Canada: ARCHIVED – Canada Gazette – Order Respecting the Interim Federal Health Program*. 2012. Available at: http://www.gazette.gc.ca/rp-pr/p2/2012/2012-04-25/html/si-tr26-eng.html (Accessed July 12, 2015).
6. Canadian Council for Refugees. *Refugee Health Care: Impacts of Recent Cuts*. Montreal, QC: Canadian Council for Refugees, 2013. Available at: http://ccrweb.ca/sites/ccrweb.ca/files/ifhreporten.pdf (Accessed September 15, 2015).
7. Voices-Voix Coalition. *Canadian Doctors for Refugee Care*. 2012. Available at: http://voices-voix.ca/en/facts/profile/canadian-doctors-refugee-care (Accessed September 15, 2015).
8. Jones A. Doctors' group takes Ottawa to court over refugee health-care cuts. *The Globe and Mail*. 2013. Available at: http://www.theglobeandmail.com/news/politics/doctors-group-takes-ottawa-to-courtover-refugee-health-care-cuts/article9047552/ (Accessed January 15, 2016).
9. Keung N. Canadian doctors, nurses, pharmacists, social workers, optometrists and dentists urge Ottawa to rescind planned cuts to refugee health coverage. *The Toronto Star*. May 23, 2012. Available at: http://www.thestar.com/news/gta/2012/05/23/canadian_doctors_nurses_join_protest_against_cuts_to_refugee_health_plan.html (Accessed January 15, 2016).
10. Morrison J. Cuts to supplemental health benefits for refugees: Expanding the understanding of patient-centred care. *Can Pharm J* 2012;145(6):285–86. Available at: http://www.swslhd.nsw.gov.au/refugee/pdf/NSW_REFUGEE_STARTTS.pdf (Accessed September 15, 2015).
11. Eggertson L. Doctors promise protests along with court challenge to refugee health cuts. *Can Med Assoc J* 2013;185(7):E275–76 PMID: 23479693.
12. *Canadian Doctors for Refugee Care v. Canada (Attorney General)*, 2014 FC 651 (CanLII). Available at: https://www.canlii.org/en/ca/fct/doc/2014/2014fc651/2014fc651.html (Accessed January 15, 2016).
13. Government of Canada. *Immigration, Refugees, and Citizenship Canada: ARCHIVED – Notice – Temporary Measure for the Interim Federal Health Program*. 2014.
14. Government of Ontario, Ministry of Health and Long Term Care [MOHLTC]. *News Release: Reinstating Access to Health Care for Refugee Claimants*. 2013. Available at: https://news.ontario.ca/mohltc/en/2013/12/reinstating-access-to-health-care-for-refugee-claimants.html (Accessed September 15, 2015).
15. Sanders C. *Province Steps up for Refugees*. Winnipeg, MB: Winnipeg Free Press, 2012. Available at: http://www.winnipegfreepress.com/local/province-steps-up-for-refugees-169590316.html (Accessed January 15, 2016).
16. Howlett M, Ramesh M, Perl A. *Studying Public Policy*. Toronto, ON: Oxford University Press, 2009.
17. Swinburn B, Gill T, Kumanyika S. Obesity prevention: A proposed framework for translating evidence into action. *Obes Rev* 2005;6(1):23–33. PMID: 15655036. doi: 10.1111/j.1467-789X.2005.00184.x.
18. Schiller C, Winters M, Hanson HM, Ashe MC. A framework for stakeholder identification in concept mapping and health research: A novel process and its application to older adult mobility and the built environment. *BMC Public Health* 2013;13(1):428. PMID: 23639179. doi: 10.1186/1471-2458-13-428.
19. United Nations High Commissioner of Refugees. *Convention and Protocol Relating to the Status of Refugees*. Geneva, Switzerland: UNHCR, 2010.
20. Schmeer K. *Guidelines for Conducting a Stakeholder Analysis*. Bethesda, MD: Partnerships for Health Reform, Abt Associated Inc., 1999.
21. Immigration, Refugees and Citizenship Canada [IRCC]. *Canada – Admissions of Permanent Residents by Intended Province/Territory of Destination and Immigration Category, 2005–January 2016/Admissions de résident permanents selon la province ou le territoire et la catégorie d'immigration, 2005–janvier 2016*. Government of Canada, 2016. Available at: http://open.canada.ca/data/en/dataset/036f5d83-490b-491b-a49e-3fed5cc860ad.
22. Mason J. *Qualitative Researching*, 2nd ed. Thousand Oaks, CA: SAGE Publications Ltd., 2002.
23. Varvasovszky Z, Brugha R. How to do (or not to do)… A stakeholder analysis. *Health Policy Plan* 2000;15(3):338–45. PMID: 11012410.
24. Greene M. The lived world, literature and education. In: Vandenberg D (Ed.), *Phenomenology & Education Discourse*. Johannesburg, South Africa: Heinemann, 1997; 169–90.
25. Carrillo JE, Carrillo VA, Perez HR, Salas-Lopez D, Natale-Pereira A, Byron AT. Defining and targeting health care access barriers. *J Health Care Poor Underserved* 2011;22(2):562–75. PMID: 21551934. doi: 10.1353/hpu.2011.0037.
26. Torgerson R, Wortsman A, McIntosh T. Towards a broader framework for understanding accessibility in Canadian health care. Ottawa, ON: Canadian Policy Research Networks Incorporated, 2006. Available at: http://cprn3.library.carleton.ca/documents/43661_en.pdf (Accessed September 15, 2015).
27. Nutt P, Backoff R. *Strategic Management of Public and Third Sector Organizations: A Handbook for Leaders*. Francisco, CA: Jossey-Bass, 1992.
28. Ballinger C. *Qualitative Research for Allied Health Professionals: Challenging Choices*. 2006. Hoboken, NJ: Wiley. Available at: http://site.ebrary.com/lib/alltitles/docDetail.action?docID=10301939 (Accessed September 15, 2015).
29. United Nations High Commissioner for Refugees [UNHCR]. *Asylum Levels & Trends in Industrialized Countries*. Geneva, Switzerland: UNHCR, 2014. Available at: http://www.unhcr.org/551128679.html (Accessed September 15, 2016).
30. Brugha R, Varvasovszky Z. Stakeholder analysis: A review. *Health Policy Plan* 2000;15(3):239–46. PMID: 11012397.
31. Maioni A. Politics and healthcare policy arena in Canada: Diagnosing the situation, evaluating solutions. Paper presented at the Queens' Health Policy Change Conference Series: Creating Strategic Change in Canadian Healthcare, Toronto, ON, 2014. Available at: http://www.moniesonhealth.com/resources/2014-WhitePaper-Maioni.pdf (Accessed January 15, 2016).
32. IRCC. *Determine Your Eligibility – Interim Federal Health Program*. Government of Canada, 2016. Available at: http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp (Accessed June 12, 2016).
33. Government of Canada, IRCC. *Restoring Fairness to the Interim Federal Health Program* [New Releases]. Government of Canada, February 18, 2016. Available at: http://news.gc.ca/web/article-en.do?mthd=tp&crtr.page=1&nid=1034619&crtr.tp1D=1 (Accessed January 15, 2016).

Received: March 1, 2016
Accepted: April 21, 2017

RÉSUMÉ

CONTEXTE : Les modifications apportées en 2012 au Programme fédéral de santé intérimaire (PFSI) ont réduit l'accès des réfugiés et des demandeurs du statut de réfugié aux soins de santé, ce qu'ont déploré les principaux acteurs du milieu. En 2014, un nouveau PFSI a temporairement restauré l'accès à certains services de santé; les rares informations disponibles sur ces modifications sont toutefois insuffisantes pour cartographier l'impact du nouveau PFSI.

OBJECTIF : Notre étude explore les obstacles survenus au cours de la période où des réformes ont été apportées à l'accessibilité et à la prestation des soins de santé aux réfugiés dans le PFSI.

MÉTHODE : Nous avons mené 23 entretiens semi-directifs pour analyser les perceptions des acteurs à l'égard des réformes de 2014, ainsi que la position des acteurs et leur influence sur l'évaluation de l'acceptabilité des modifications au PFSI.

RÉSULTATS : Les acteurs ont majoritairement exprimé des réserves à propos des modifications apportées au PFSI en 2014, en raison de la persistance des obstacles créés par la réduction des dépenses en 2012 et de l'émergence de nouveaux obstacles à l'accessibilité et à la prestation des soins de santé aux réfugiés. Les principaux obstacles qu'ils ont nommés étaient le manque de communication et de sensibilisation, le manque de continuité et d'intégralité des soins, le discours politique négatif et l'accroissement des coûts. Quelques acteurs étaient en faveur des réformes du fait qu'elles offraient un certain accès aux soins de santé, même si cet accès était limité.

CONCLUSION : Globalement, les réformes apportées au PFSI en 2014 ont créé des obstacles à l'accessibilité et à la prestation des soins de santé aux réfugiés, ce qui a contribué à la confusion chez les acteurs, au transfert de la responsabilité de la santé des réfugiés aux autorités provinciales et à la probabilité de creusement des disparités dans les résultats sanitaires, les réfugiés et les demandeurs du statut de réfugié choisissant d'attendre avant d'avoir recours aux soins de santé. L'étude recommande aux responsables des politiques de dialoguer avec les acteurs du milieu de la santé des réfugiés pour formuler une politique qui améliore l'accessibilité et la prestation des soins de santé pour les populations réfugiées.

MOTS CLÉS : réfugiés; politique de santé; Programme fédéral de santé intérimaire; analyse des acteurs