REFUGEE CLAIMANTS' ACCESS TO HEALTHCARE IN QUEBEC: SUBJECTIVE EXPERIENCES AND CONTESTED MEDIA REPRESENTATIONS

by

JESSE BEATSON

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Abstract

A central question for any publically subsidized healthcare system is the extent to which non-citizens should be granted access. Refugee claimants, by definition, are not yet citizens of the host state and a continued debate is over what legitimate claims they have on social resources like healthcare vis-à-vis citizens. In Canada, the question of what extent refugees and refugee claimants should have access to healthcare was contested publically in the wake of cuts to the Interim Federal Health Program (IFHP). For over 50 years the Canadian government provided relatively comprehensive health insurance coverage to refugees and refugee claimants through the IFHP. The federal Conservative government (February 2006 – November 2015) significantly reduced the scope of this health coverage on June 30, 2012. The present thesis research was conducted in the province of Quebec and responds to two related topics – the framing of refugee claimants in the media, and the understanding and experiences of claimants in regards to the healthcare access barriers that they faced. A first paper analyses the debate that ensued following the IFHP cuts, one that the pitted the Conservative government's framing of refugee claimants as 'bogus' against health provider advocates' framing of claimants as 'victims'. While the victim frame arguably "won", the language of advocates could be much enriched by incorporating rights-based arguments. This would lessen some of the negative ramifications of victim framing. In a second paper, refugee claimants' subjective experiences of the healthcare services are examined. Claimants reported experiencing a number of impacts of barriers, including to their physical, mental, and financial wellbeing, and to their sense of belonging in Canada. Results suggest that although there are actual limitations in health coverage, as well as confusion and prejudices from providers, it is noteworthy that claimants' understanding of their own situation has its own consequences, for instance diminished health-seeking.

Résumé

Une question centrale pour tout système de soins de santé subventionné publiquement porte sur l'étendue des soins auxquels les personnes qui ne sont pas citoyennes doivent avoir accès. Les demandeurs du statut de réfugié, par définition, ne sont pas encore citoyens du pays d'accueil, et un débat persiste à propos de la légitimité de leurs revendications faces à des ressources sociales, telles que les soins de santé, par rapport aux citoyens. Au Canada, la question de l'accès à des soins de santé pour les réfugiés et les demandeurs d'asile a soulevé des contestations publiques suite aux coupes effectuées dans le Programme fédéral de santé intérimaire (PFSI). Depuis plus de 50 ans, le gouvernement canadien a fourni une couverture d'assurance-maladie relativement complète aux réfugiés et aux demandeurs d'asile par le biais du PFSI. Le 30 juin 2012, le gouvernement conservateur (février 2006 – novembre 2015) a diminué de façon substantielle l'étendue de cette couverture. Cette présente thèse de recherche a été menée dans la province de Québec et porte sur deux sujets connexes : la couverture médiatique des demandeurs du statut de réfugié, ainsi que la compréhension et l'expérience des demandeurs en ce qui concerne les difficultés auxquelles ils ont été confrontés à obtenir des soins de santé. Un premier article analyse le débat qui a suivi la réduction de l'accès aux soins de santé et confronte la vision du gouvernement conservateur, qui considère les demandeurs comme des « faux réfugiés », par rapport aux prestataires des soins de santé qui les défendent et les considèrent comme des victimes. Bien que l'image de la victime a sans doute gagné, le discours des défenseurs tirerait avantage en incorporant des arguments fondés sur les droits. Cela réduirait certaines des conséquences négatives de cette construction des demandeurs en victimes. Dans un second article, les expériences subjectives des demandeurs du statut de réfugié à propos des soins de santé sont examinées. Les sujets ont déclaré avoir subi les impacts d'un certain nombre d'obstacles, entre autres sur leur bien-être physique, mental et financier, et sur leur sentiment d'appartenance au Canada. Les résultats suggèrent que bien qu'il existe des limites réelles à la couverture des soins, ainsi que de la confusion et des préjugés chez les professionnels de la santé, il est à noter que la compréhension des demandeurs à propos de leur propre situation comporte ses propres conséquences, par exemple une diminution de la recherche de soins de santé.

Acknowledgements

To visualize the writing of this thesis would likely conjure an image of a solitary individual at a laptop: squinting into the screen, fingers pecking, illuminated by lamp light. Perhaps there is a tower of library books set off to one side.

There is a partial truth to this image; it captures countless lived-in hours of my grad student life. Yet it also leaves an inexcusable lacuna, like a missing section of a text crucial to its meaning. It renders invisible the community of people that contributed their ideas and guidance and who were a foundation of support.

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If my readers are so inclined, I welcome any correspondence. This may be directed to the author:

Email: Jesse.Beatson@mail.mcgill.ca

Introduction

Given the global refugee crisis, the accessibility of healthcare to refugee claimants in Western host countries is an area of heightened concern. In Canada, cuts were made in June 2012 to the Interim Federal Health Program (IFHP), a federal health insurance program for refugee claimants and some other categories who do not fall under provincial healthcare coverage. The province of Quebec immediately provided compensatory funding that, in principle, filled coverage gaps left by the cuts. Barriers to accessing healthcare have been observed despite these compensatory measures.

Throughout my Master's program studies at McGill, I have been researching and reflecting upon this topic of refugee claimant health barriers with a special interest in the notion of 'voice'. Who is doing the talking, what perspectives are being included or left out? In my first paper, I discuss the ways in which two powerful external voices, the federal Conservative government and doctor advocates, clashed over the question of health access for claimants. It is suggested that the two competing frames in this conversation, claimants as either 'bogus' or 'victims', place significant restrictions on public discourse. Moreover, a third perspective of claimants as 'rights-holders', one that has largely been neglected, could serve to counter negative stereotypes and enrich the language of advocates.

In my second paper, I investigated the impacts of healthcare barriers for claimants in Montreal, from the vantage point of claimants themselves. Qualitative interviews provided rich health-seeking narratives, and the emergent themes complement and augment a literature on barriers for claimants that is slanted towards health provider perspectives. I argue for the value of engaging with the subjective experiences of claimants, as doing so sheds unique light on how difficulties seeking care potentially impact not only health and wellbeing in the short term but also attitudes that influence future health-seeking. This approach also highlights what claimants know and do not know about their healthcare entitlements; and moreover, it offers a channel for expressing to a group that, as the first paper illustrates, is often silenced or sidelined.

The Stories We Tell About Refugee Claimants: Contested Frames of the Healthcare Access Question in Canada

ABSTRACT

A contested issue is the extent to which refugee claimants should have access to healthcare in Western host countries with publically subsidized healthcare systems. In Canada, for a period of over 50 years, the federal government provided relatively comprehensive health coverage to refugees and refugee claimants through the Interim Federal Health Plan (IFHP). Significant cuts to the IFHP were implemented in June 2012 by the Conservative federal government (2006-2015), who justified these cuts through public statements portraying refugee claimants as bringing bogus claims that inundate the refugee determination system. A markedly different narrative was articulated by a pan-Canadian coalition of health providers who characterized refugee claimants as innocent victims done further harm by inhumane healthcare cuts. This article presents an analysis of these two positions in terms of frame theory, with a greater emphasis on the health provider position. The argument made is that this debate can be meaningfully analyzed as a contest between competing frames, namely bogus and victim frames. Frame theory suggests that frames by nature simplify and condense, in this case packaging complex realities about refugee claimants into singular images (bogus and victim), aiming to inspire suspicion and compassion respectively. The acceptance of current frames impoverishes the conversation by reinforcing problematic notions about refugee claimants while also obscuring a rights-based argument for why claimants should have substantial access to healthcare.

INTRODUCTION

A central question for any publically subsidized healthcare system is the extent to which non-citizens should be granted access. Refugee claimants, by definition, are not yet citizens of the host state and a continued debate is over what legitimate claims they have on social resources like healthcare vis-à-vis citizens. Many scholars assert that refugee claimants should at very least have access to emergency medical care, what Gibney (2009) argues is part of a “moral minimum” owed to precarious migrants. Beyond this baseline of care, opinions vary widely about whether any additional healthcare benefits should be provided and under what conditions.

In Canada, the question of what extent refugees and refugee claimants should have access to healthcare was contested in a heated and public manner, specifically in the wake of cuts to the Interim Federal Health Program (IFHP). For over 50 years the Canadian government provided relatively comprehensive health insurance coverage to refugees and refugee claimants through the IFHP. When the Conservative federal government (February 2006 – November 2015) significantly reduced the scope of this health coverage on June 30, 2012, all refugee claimants lost coverage of medications and many others lost access to medical services, except for rare instances where health conditions were deemed a risk to public health or safety (Stanbrook 2014). On October 19, 2015, the Liberal Party was elected and in April 2016 restored IFHP health coverage to previous levels.

The scope of this article concerns the status of the IFHP under the Conservative government. It was this era in which the IFHP cuts were made, and accordingly, this is when the event of interest for this study took place, namely a discursive struggle in the media between the Conservative federal government and refugee health provider advocates. For each of these two parties, their public statements can arguably be distilled into single generalizing labels applied to refugee claimants. These labels centred drastically different features that claimants allegedly exhibit.

This article demonstrates that these labels acted as shorthands for these opposing parties, federal Conservative government and doctor advocates, who were each endeavoring to steer a national conversation about what Canada owes to claimants in terms of health coverage. This period of recent Canadian history (2012-2016) presents an opportunity, therefore, to study how conflicting ways of representing refugee claimants in the media are linked to differing determinations about their entitlements to health services. In other words, it is a comparison between two different “stories” that have consequences. The consequences of these media portrayals are significant. We see in the United States the way that the portrayal of the “deserving vs. “undeserving” poor has justified cuts in the social safety net (Katz, 1990). To this end, this paper borrows conceptually and methodologically from frame theory, a type of discourse analysis (see Van Dijk, 1993; Fairclough, 1992; Fowler et al., 1979).

The literature on frame theory is rich and diverse, with intellectual roots stretching back to the 1970s (see Fillmore, 1976; Goffman, 1974). The frame theory that is relevant here, however, is its recent application to the collective arena, exploring how frames are used strategically to mobilize people around particular political causes and issues. Attention will be paid to the inability of refugee claimants themselves to have participated as equal partners in the national conversation on their access to healthcare; the responsibilities that should flow from the fact of refugee claimants’ muted political voice for those who speak on their behalves; the main frames that were in play regarding refugee claimant healthcare and what they highlighted compared to what they obscured from view; and finally, the tension between the need for frames in an adversarial public dialogue and how even ‘pro-refugee’ framing may have negative ramifications for the claimants who are being characterized.

BACKGROUND

It is no wonder that refugee claimants are the subject of discursive activity. While the determination of their legal identities follows the relatively fixed process of immigration and refugee boards, their social identities are in limbo owing to their being between states of civic belonging; they have fled their country of origin and are not yet members of their host country. Lacking the benefits of citizenship in the host country, their political voices are muted. Simply put, they are not in a favourable position to have their own narratives and perspectives heard. Instead, they are an ideal screen upon which various images, conjured by more powerful and civically entrenched actors, can be projected. As noted by Phillips and Hardy (1997), there are two components of refugee identity: first, *what* a refugee is; and second, *who* is and who is not a refugee. While the second component is largely determined by the legal and institutional processes of refugee determination, the first is a more open question, influenced largely by the discursive productions of various actors vying to advance their particular agendas.

Since refugee claimants have limits placed upon their capacity to, as it were, tell their own stories, a lot of power is placed in the hands of those who do this representational work on their behalf. Malkki (1996) notes that even when discourses on refugees or refugee claimants attempt to empower and humanize, they inevitably construct a limiting “vision of humanity that repels elements that fail to fit into the logic of its framework” (p. 390). In other words, discursive constructions of refugees necessarily entail generalizations that deny complexity and the uniqueness of the individual. To advance a side of a public debate, even if it is a ‘pro-refugee’ stance, generalizations will be necessary. Nonetheless, the degree to which the potential harm of these generalizations is outweighed by benefits is an area for critical inquiry and assessment.

A tension presents itself, however, to those who would put themselves in the role of advocates. On the one hand, there is a responsibility to do justice to the complexities of what is essentially other people's lives, to render into high resolution their diverse experiences and subjectivities. On the other hand, a practical necessity exists to put forward an advocacy message that is clear and concise enough in order that it can be effectively digestible and for it to circulate widely. The concept of a frame is a helpful analytic device for understanding the discursive process that occurs in substituting relatively clean-lined images for necessarily jagged realities. Importantly, frames do not fit the world as it is, and by extension, they are never neutral representations (Lakoff, 2014). The subject of a frame is like an elephant from a famous parable. The frames themselves are the blind men who each appraise one facet of the animal; who, upon comparing notes, are inevitably going to be in disagreement about what they are describing because each only has one piece of the puzzle.

Frame theory has a rich academic lineage, dating back to the mid-1970s. Goffman, a sociologist, studied institutions and contended that every institution is structured by a frame, a kind of unconscious social script. Goffman (1974) defined a frame as a "schemata of interpretation" that enables individuals "to locate, perceive, identify, and label" events and phenomena occurring in the world (p. 21). Fillmore (1976), a linguist, wrote about frames at around the same time and proposed that every word is defined with respect to a frame. As an example, the word 'surgeon' has a series of readily triggered linguistic and conceptual associations, such as 'operating room' and 'scalpel', which in turn enrich our understanding of the original word. In both Goffman and Fillmore's accounts, frames are structures that inform, as well as constrain, the way a thing is talked about and understood. More recently, the concept of frames has been employed in the collective arena, with frame analysis studying how frames might be strategically used in social mobilization. Kligler-Vilenchik and Thorson (2015) note that participants and observers in a public discourse may not be able to name the 'title' or 'category' of a frame. They may still have a sense for how the ideas in a frame cluster together, what have been called "interpretative packages" (Gamson and Modigliani, 1989).

Once seen through the angle of vision provided by a certain frame, its subject can become difficult to perceive and interpret in alternative ways. Indeed, when unchallenged, a frame can become what Bourdieu (1977) termed *doxa*, an established way of thinking about something that is presented as self-evident and experienced as the "natural world that is taken for granted" (p. 164). This persistence of frames to shape thinking has been studied by cognitive linguists, such as Lakoff (2008), who posits that frames are not simply abstract entities but have corresponding physical manifestation in neural structures in the brain.

Frames are not equivalent to ideologies, though there are surface similarities. Ideology can be defined as "pervasive and integrated sets of beliefs and values" that have historical longevity (Benford & Snow, 2000). Frames, by contrast, can be employed as extensions of, or correctives to, existing ideologies. Accordingly, ideology can either constrain or bolster framing processes (see Oliver and Johnson 2000). Benford and Snow (2000) call this "meaning work – the struggle over the production of mobilizing and countermobilizing ideas and meanings" (p. 613), while Hall (1982) terms it "the politics of signification". I will use the term "frame contest". Underlying these concepts is the notion that meaning is constructed in a dynamic and evolving process, an ongoing contest of frames and counter-frames. Having a convincing frame(s) will give one a greater chance of shaping how an issue in question is viewed.

METHODS

Teo (2000) describes how discourse analysis is particularly well-suited for examining data such as news articles and press releases containing messages that seem, or are portrayed, as neutral but that nonetheless contain ideological content. Academic journal articles, newspaper articles, and press releases published between April 2012 and November 2015 were examined. Given the primary interest of this paper on responses to the IFHP cuts, an initial search was performed on PubMed and Medline with the keyword phrase "Canada cuts to refugee health", with each database yielding a total of 9 results. A similar search was repeated using Google Scholar with a custom range of 2012-2015 and with the added exact phrase "refugee health", yielding 339 results. A Google News search was performed further targeting articles tagged with "Canadian Doctors for Refugee care", yielding 91 results. In addition, the CDRC website was consulted, particularly the sections titled "Further reading/survey" – a collection of CDRC press releases – and "In the news" – a list of newspaper articles related to refugee health advocacy in Canada. All articles related to the IFHP cuts were retrieved and considered for analysis. A subsequent search on Google Scholar used the phrases "refugee bogus", "refugee victim", "refugee rights" and "refugee right to health".

Analysis followed an iterative, inductive process as is standard in discourse analytic methods. While reading through the sources, text sequences that characterized and defined refugee claimants, whether positively or negatively, were collected. Thematic recurrences of subject matter were recorded until the predominant character of both Canadian Conservative Party discourse and CDRC discourse emerged. The structural features of these 'texts' were not analyzed, as the focus was not on macro-level analysis but instead on identifying primary discourses through the collection of relevant and frequently appearing text sequences or ‘discourse strands’. This process allowed for a preliminary mapping out of frames in discourse in relation to the contested issue of refugee healthcare coverage.

The government discourse was found to centre on notions of bogus refugees threatening limited healthcare resources, while CDRC discourse most often advanced an image of refugee claimants as victims deserving of care and consideration. Codes for these bogus and victim frames were then applied manually to sources to isolate and retrieve relevant text sequences for further analysis. This study was exempt from ethics review.

CONSERVATIVE PARTY OF CANADA: THE BOGUS FRAME

The Conservative government defended cuts to the IFHP by implying that these measures would protect the immigration system from refugee claimants who are allegedly ‘bogus’ and intent on taking advantage of Canadian generosity. This phrase “bogus refugee” has been a particularly charged and oft-recurring theme in Conservative Party discourse (Bauder, 2008). In a discourse analysis of Canadian media, Bauder (2008) found that the term “bogus refugee” appeared most frequently in the weeks before immigration legislation was tabled, suggesting a link between discourse and efforts towards legislative change. Negative rhetoric such as this is mirrored in the popular media and political discourse of other Western countries, where language is often dehumanizing and likens refugees and refugee claimants to swarms of insects, or catastrophic floods; signifiers of threat to host societies (Esses, Medianu & Lawson, 2013; Gabrielatos & Baker, 2008; Grove & Zwi, 2006; Klocker, 2004).

Characterizing refugee claimants as bogus, Conservative Party discourse suggested that claimants are in some sense fraudulent outsiders whose health status is beyond the pale of communal concern. Jason Kenney, former Conservative Party Immigration Minister, articulated the cuts to refugee healthcare as a measure taken to ensure that “tax dollars are spent wisely” and to “defend the integrity of [the] immigration system” from “bogus claimants” (Archived 2012, April 25). According to Kenney there is “no legal, moral, or political obligation to give taxpayer services to bogus asylum seekers, rejected claimants – people who are effectively illegal migrants” (Jones 2013, February 25)

With the bogus frame portraying refugee claimants as opportunistic “queue-jumpers” who are not deserving of “gold-plated healthcare”, a sweeping portrait of suspicion was created (Wherry 2012, July 16). This framing was applied “at every moment from the time when [claimants] decide to depart to the moment when they present themselves for determination” (Galloway 2014, p. 53). Although Canadians tend to be generally pro-immigration, they are often more reticent regarding refugee claimants. As Tribe (2002) has observed, “refugees are often resented by the host nation, which may feel less than inclined to put resources into refugee health and they may be attributed marginal or ‘out-group’ status” (p. 244). Negative attitudes toward refugee claimants were more prevalent following the August 2010 arrival of nearly 500 Tamil refugee claimants on the MV Sun Sea, portrayed by the Conservative government as potential terrorists as well as ‘queue-jumpers’ (Medianu, Sutter & Esses, 2015; Krishnamurti, 2013). In a winter 2010 poll, 70% of Canadians indicated that they had doubts about the validity of many refugee claims (Reitz, 2012). More recently, a poll from the Angus Reid Institute found that two in five Canadians wanted Canada to immediately stop taking Syrian refugees (Hobson 2016, February 19).

The stated rationale for the IFHP cuts is misleading, both in its characterization of refugee claimants as bogus and in its suggestion that only these allegedly bogus claimants were affected by IFHP cuts. The notion of bogus refugee claimants elides the fact that many claimants eventually become Canadian citizens and hence cannot possibly have anything but legitimate claims. Canada’s own Immigration and Refugee Boards found that half of the 19,960 claims processed in 2014 met the strict criteria for refugee determination – this includes many claims made from so-called designated countries of origin (DCO), countries like Mexico and Hungary that Conservative government policy categorized as “safe” and thus not refugee-producing (Keung 2015, March 1).

As noted in a press release by CARL, the refugee definition is technical and even for those who do not meet these strict criteria it does not necessarily indicate any malicious intentions: “Many claimants come with a genuine fear of harm but may not meet the definition of a refugee. That does not make them frauds or bogus, or abusers of the system. Their search for protection is genuine” (Canadian Association for Refugee Lawyers 2012, February 16). In terms of the suggestion that only so-called bogus refugees were targeted by the cuts, the federal government’s own ‘Summary of Benefits’ webpage stated that cuts affected all refugee claimants while their claims were being processed, not only once their applications have been rejected (Gulli 2015, September 25).

CANADIAN DOCTORS FOR REFUGEE CARE: THE VICTIM FRAME

In response to refugee health cuts, a pan-Canadian coalition of health professionals formed called Canadian Doctors for Refugee Care (CDRC). CDRC advocated for the restoration of IFHP health coverage to prior levels. CDRC and its individual members worked both behind the scenes – enlisting health professional associations and lobbying with political parties – and in public, including occupying the offices of Members of Parliament, publically confronting Conservative MPs, and organizing public rallies (Cleveland, 2015). Furthermore, along with two other public interest applicants — Canadian Association of Refugee Lawyers (CARL) and the Toronto legal clinic Justice for Children and Youth – CDRC engaged in a legal challenge of

IFHP cuts. CDRC’s legal application to strike down the IFHP cuts of June 2012 was granted by a Federal Court in July 2014 on the grounds that the health cuts constituted “cruel and unusual treatment” (Canadian Doctors for Refugee Care v. Canada 2014; Black 2014, July 4).

The aim of much of CDRC’s advocacy work seemed to focus on replacing negative, widely circulated notions about refugee claimants with more positive, sympathetic representations. CDRC suggested that the term bogus “implies these are people who have made a fraudulent claim,” which contradicts the reality that many have already been accepted and many others will be found to have legitimate claims” (Gulli 2015, September 25). Contrasting with the Conservative Party’s representation of refugee claimants as bogus, CDRC highlighted the vulnerability of claimants in their public statements. Primarily, CDRC focused on an image of claimants as innocent victims. As victims, claimants were justified to be deserving recipients of publicly-funded services. Moreover, CDRC placed a strong rhetorical emphasis on depicting Canadians as generous and compassionate. In an October 23, 2012 press release, for instance, CDRC suggested that: “our compassionate instincts as Canadians and the evidence points to the IFHP cuts being bad policy” (Canadian Doctors for Refugee Care 2012, October 23). Hence, CDRC contended that that the health cuts were wrong both because they contradicted empirical evidence and because they violated the humanitarian values of Canadians.

According to CDRC, “the impact of the federal Conservative government’s cuts has been devastating”, for instance with many pregnant women, sick children, and cancer patients who experienced “unwarranted suffering” until the federal court reversed the cuts (Raza et al., 2012, p. 729). Indeed, CDRC described refugee claimants in Canada as “some of the most vulnerable people in the world” and “the most insecure and defenseless among us”, often experiencing "poor mental health" and that they might be "suicidal or suffering from posttraumatic stress disorder" (Raza et al., 2012, p. 728).

CDRC argued that the Conservative government's framing of restricting refugee healthcare as a public safety issue dehumanized refugee claimants: "the refugee person in this context is no longer valuable as a unique and worthy human being but is considered a 'risk factor' for others" (Raza et al., 2012, p. 728). Here CDRC challenged Conservative Party discourse that borrowed the language of public health and contributed to negative and dehumanizing representations of refugee claimants. A CDRC press release of January 27, 2014 states that "this is not the fair and generous Canada that we know" (Canadian Doctors for Refugee Care 2014, January 27).

In highlighting the vulnerability and victimhood of refugees and the compassion of Canadian citizens, this approach of CDRC's can be labelled a victim frame. Van Gorp (2005) studied Belgian media sources and demonstrated how coverage described refugee claimants in simplistic binaries as either "innocent victims" or as "intruders". The victim frame was found to be associated with calls for and support of humanitarian policies. The intruder frame, on the other hand, was linked to anti-refugee policy proposals and sentiments.

RISKS IN EMPLOYING A VICTIM FRAME TO PROMOTE HEALTHCARE ACCESS

While undeniably successful in many respects, CDRC's advocacy still warrants critical examination. Given a context where certain anti-refugee and anti-migrant discourses are widespread, the characteristics of refugee claimants that are highlighted in constructing more positive representations is a consequential topic worth analyzing. As a group, refugee claimants are often marginalized from mainstream services and this is linked partly to discourse portraying them as 'undeserving' in contrast to 'deserving' refugees (Sales, 2002). The counter-discourse to this binary separation of undeserving from deserving has tended to be couched in a humanitarian ethos. If refugee claimants are pictured uniformly as victims, as they were by CDRC, then it follows that they are all equally deserving.

Kurasawa (2015) highlights how an essential part of any humanitarian discourse is to "actively construct objects and sites for intervention" through a process of naming vulnerable and victimized populations. Although assignment of victim status to refugee claimants may have some grounding in clinical realities, it is also connected to a particular framework – what Gottlieb, Filc, and Davidovitch (2012) call "medical humanitarianism" – that is not neutral in its assumptions about how best to allocate social resources and on what grounds. Specifically, this framework is grounded in notions of charity, that the needy are broadly deserving of care. As this is a particular framework, rationalizing the granting of healthcare to claimants in a way that is not necessarily subscribed to by others who advocate for these same general goals, it will have its own consequences: positive and negative, intended or otherwise.

In assigning victim status to refugee claimants, a link was drawn to other characteristics of 'ideal victims', such as passivity, weakness, helplessness, and neediness (Van Dijk, 2009). If an individual in question does not fully embody those characteristics, there can be negative consequences; for example, the individual can lose their tenuous, socially-granted legitimacy and deservingness. One reason for losing this provisional legitimacy, as highlighted by Beiser (1999), is through not repaying a debt of gratitude that some members of a host society may think is owed for the 'generosity' refugees and refugee claimants have received. This implicit requirement to repay such a social debt may put significant pressure on claimants and, moreover, may constrain their capacity to assert their rights or contest the conditions of their treatment.

Hardy and Phillips (1999) have argued that portraying refugee claimants as victims risks being overly paternalistic and “promotes a stereotypical view of refugees as helpless, defenceless individuals”. Moreover, suggesting that claimants as an entire population are victims can be seen as a form of Othering. Conceptualized by Said (1978) in his foundational text *Orientalism*, Othering involves a form of symbolic violence, the forcible creation of identities to fit a certain narrative. Contemporary scholarship by Johnson (2011) found that the image most frequently reproduced in photographs of refugee claimants is of individuals who are victimized and racialized. Such images are so common that the subtle Othering contained in them might not be readily perceptible. Similarly, Rajaram (2002) raises concerns about images and discourses that reduce refugee claimants to their suffering bodies: “Corporeal, refugees are speechless and consigned to ‘visuality’: to the pictorial representation of suffering and need”. This emphasis on visual depictions of suffering may promote perceptions that refugee claimants are somehow more bodily beings than the host population, lacking in complex consciousness and the capacity for articulating nuanced opinions.

HUMANITARIANISM VS. HUMAN RIGHTS

A victim frame as applied to the issue of healthcare access for refugee claimants promotes a certain connection of health coverage as a type of humanitarian assistance. A clear hierarchy exists differentiating the generous giver from the recipient of charitable support. In contrast with rights discourses, humanitarian logic is “about the exception rather than the rule” and therefore is contrary to an advocacy position promoting the notion of universal rights (Ticktin, 2006, p. 45). Arguments grounded in this status of the exceptional victim are “situationally specific and are about moral worthiness”, which are contrasted with “universalizing juridical arguments” that apply across all contexts and are about formal entitlements to health rights (Willen, 2012, p. 812). Although health advocacy informed by a humanitarian ethos share some “common ends” with rights-based advocacy as noted by Slim (2000, p. 291), the difference in the underlying logic – charity versus obligation – has significant implications (Dauvergne, 2000). Whether or not refugee claimants ‘deserve’ health coverage would be a largely irrelevant question from a perspective informed by rights.

In contrast to hierarchical advocate-victim relation set up by humanitarian discourse, in rights-grounded advocacy marginalized individuals can theoretically become empowered by becoming their own advocates. This was proven to work to an extent in the context of South Africa, where there was a campaign for access to medicines for the HIV-infected that started in the 1990s and reached its height in the early 2000s. This campaign involved impoverished and infected individuals mobilizing and deploying a legal framework in making their demands (Heywood 2009). By contrast, advocacy based strictly on humanitarian principles leaves little room for the marginalized to participate as anything other than figures emblematic of victimization.

Within CDRC, there was a strong belief that refugees and refugee claimants have a right to healthcare (Cleveland, 2015). The decision to frame the issue around notions of victimhood and deservingness is likely based, then, on an assessment that this is the most efficient strategy in terms of garnering broad support across the political and ideological spectrum. There are other pragmatic reasons perhaps that informed why CDRC did not lead with a rights discourse. Specifically, the victim frame avoids the potentially controversial and polarizing stance of attempting to elevate the status of refugee claimants in Canadian society on a more fundamental and permanent level, an agenda that may not have had enough public buy-in.

RIGHTS-BASED ARGUMETS: CHALLENGES AND OPPORTUNITIES

The adopting of a victim frame by CDRC is not a neutral advocacy stance, and it is important to note that despite the prevalence of this frame in popular media, other alternatives are available. Given that there are several potential problems with the victim frame as a mode of advocacy, why then, as Taylor (2001) asks, are rights-based arguments used so infrequently in public discourse about refugee and refugee claimant issues? Rights are the "banner under which struggles against oppression and exclusion have been fought (and sometimes won) over the past century", and "assertions of right are the strongest tools of the law" (Dauvergne 2000, p. 56)**.** Rousseau and colleagues (2008) point to the growing legitimacy of the human rights framework, which by the mid-1990s was endorsed and utilized by a wide range of international actors.

Dauvergne (2000) believes that in the case of asserting health rights claims on the behalf of refugee claimants, rights-based advocacy is often practically ineffective as it implies a controversial obligation and positive duty for host societies to provide healthcare to those who are not full members. It is true that while there is broad based international support in Western countries for civil and political rights, there is a degree of ambivalence from these governments in relation to social rights (Steiner, Alston, & Goodman, 2008).

An additional challenge with rights discourse in this context is that it may not be as familiar a mode of advocacy for health professionals. Castañeda (2011) and Willen (2011) both report that health professionals concerned about healthcare access issues for refugee claimants most commonly frame this in humanitarian terms. Vanthuyne and colleagues (2013) conducted a survey with Canadian health professionals where a majority of respondents who believed uninsured patients should receive healthcare articulated this in terms of moral worthiness or 'deservingness', rather than framing uninsured individuals as 'subjects of rights'. A rights discourse is perhaps less intuitive and actually challenges the privileged position that clinicians occupy in society.

Centering advocacy on a ‘right to health’ may also meet challenges from those who assert that there is a lack of concreteness to the concept itself or that consensus acknowledging its full existence is missing. Ruger (2006) claims that one would be “hard pressed to find a more controversial or nebulous human right than the ‘right to health’” (p. 1). Ambiguity around health rights has been attributed to various issues, including what Daniels (1985) describes as a lack of a proper philosophical foundation, and also the fact that tax-based health systems like Canada’s did not develop within a legal rights framework but as part of the modern welfare state (Flood & Gross, 2014). Sources of the right to health, however, are not lacking. Contemporary international law, which includes the International Covenant on Economic, Social and Cultural Rights (ICSCR), provides a robust defense of the right to health that is inclusive of refugee claimants. Importantly, the ICESCR specifies a legal obligation on States to “*respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services” as well as to abstain from “enforcing discriminatory practices as a State policy” (UN General Assembly, resolution 46/119). Seventy states are signatories to the ICESCR, though fewer have ratified it.

Despite some aforementioned challenges, from an advocacy standpoint rights-based arguments have certain advantages. They can help to avoid the Othering of the victim frame, changing the emphasis on access to healthcare from charity to obligation and thereby providing a more consistent source of legitimacy to refugee claimants as users of healthcare services. Claimants would not have to rely to the same extent on the empathy or compassion of health professionals in order to gain needed care. Biased ideas and preconceptions regarding refugee claimants have been found to be fairly common among healthcare professionals (Eastmond, 1998). Given the necessary limitations of compassion as a basis for protecting the health of this population, repositioning refugee claimants as rights-holders appears to be a promising avenue. Further, by emphasizing the rights of refugee claimants, the capriciousness of public sentiment would be less likely to lead to new refugee healthcare cuts. Host society sympathy for the plight of refugee claimants may fluctuate and with it today's victims may be transformed into tomorrow's threats. Grounding the discourse in a language of rights, a more difficult status to strip away than victimhood, would create some protection for refugee claimants from these inevitable changing tides of popular opinion.

Some limitations of this work should be noted. First, materials analyzed were retrieved in three large databases by using specific keywords and phrases in English only. Perspectives expressed in mainstream French Canadian media, for example, may have been missed if not translated and included in English sources. Second, structural features of these texts were not assessed. Third, this article focuses on only one aspect of advocacy/policy mobilization and, although recognizing that individuals, organizations and movements can hold and be shaped by conflicting frames, the necessarily reductive approach of frame analysis may have resulted in the exclusion of some perspectives. Frame analysis is only one tool for analysis that intends to contribute toward advocacy. Further study could consider the political opportunities, mobilization, and resources for social movement organizing by refugees.

CONCLUSIONS

The victim frame chosen by CDRC appears to have had efficacy, but it may have unintended effects. This paper has asserted that there is a need to keep a critical gaze on discursive framing strategies employed in advocacy, even when these strategies have proven successful by certain measures. In particular, the achievement of short-term goals must be thoughtfully considered in parallel to longer term aims of broader political and social change. The potential advantages for refugee advocates of leaving rights out of the discussion should be further studied in addition to further assessment of potential risks in the way refugees and refugee claimants have been portrayed as victims.

What does the relative under-utilization of rights-based arguments say about the status of refugee claimants in Canada, and more generally, in Western host societies? It sheds light on the position of refugees in host societies as fundamentally unequal. Moreover, it is suggestive of a current ceiling on state commitments to refugees, and also potentially of limited supplies of host population sympathy to the cause of refugee claimant empowerment beyond what can be achieved through charity. There may be a generalized willingness to help and extend services, but only on certain terms. Help is rendered with a certain self-satisfaction and can be withheld on reasonably justifiable grounds because assistance is optional and beyond the bounds dictated by duty.

A more secure foundation for justifying refugee claimants' access to critically needed health services could be built around portraying them as rights-holders, rather than as deserving recipients of well-intentioned charity. In pragmatic terms, however, advocacy based on a victim frame may be the best solution to achieving immediate results to urgent problems such as gaps in health coverage. What is important from an advocacy standpoint is that discourses that are selected be critically evaluated for their weak points as well as benefits, the ways they are potentially hurting as well as helping. Refugee claimants are rarely afforded the opportunity to tell their own stories and so the stories that are told about them have significant influence in defining their public image, setting the terms of the debate over their level of access to health services.

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Bridge

In these times of troubling representations, what are refugee claimants' subjective experiences accessing healthcare? In the context of a global refugee crisis with more forced displacement than ever in recent history, the cuts to the Interim Federal Health Program (IFHP) in Canada appeared to show a reluctance on the part of the government to help. There are two related indicators of reluctance, the cuts themselves and the rhetoric that was deployed to justify such a policy shift. The first paper looks at the latter. This next paper will more closely examine the impacts of the IFHP cuts as reported by refugee claimants. A running thread that connects these papers is the theme of 'voice'. Just as refugee claimants' voices are seldom heard in public discourses about their journeys and their motivations for seeking asylum, studies that collect narratives from claimants themselves are underrepresented in the literature on the healthcare barriers that they face. Rather, the voices of healthcare providers tend to be the loudest in this area. These provider perspectives are an important window into the problem, but that vantage point cannot illuminate the knowledge that refugee claimants have in navigating healthcare barriers, nor can it speak to claimants' subjective experiences. As will be shown in this next paper, the knowledge and experiences of claimants offer irreducible insights on the user-level dimension of access barriers.

Refugee Claimants' Understanding and Subjective Experience of Healthcare Access Difficulties in Montreal

ABSTRACT

Despite high incidence of health issues for refugee claimants, access to healthcare for claimants is often restricted in host countries through domestic policy and law. In 2012, significant cuts were made to the Canadian Interim Federal Health Program (IFHP), a federal insurance plan designed to cover refugee claimants, who have yet to become eligible for provincial coverage. This study was conducted in the province of Quebec, where compensatory measures were adopted yet there was anecdotal evidence of limited access to services for this population. Semi-structured interviews (n=31) were conducted with refugees and refugee claimants who had experienced difficulty accessing healthcare in Quebec since June 2012. Participants in the study reported facing a range of healthcare barriers and impacts from those barriers. Access difficulties they related to legal status included denials and/or delays of care due to lack of information by providers and institutional constraints, periods of coverage expiry, and limitations in coverage. Impacts from lack of access could be grouped in four areas: physical health, mental health, financial, and sense of belonging. Although there are actual limitations in services, and confusion and prejudices in providers, these seem to be multiplied by the lack of information and the misinterpretation of these and of the actual healthcare experience by the claimants. The misinterpretation seems to be influenced by direct discrimination experiences and by the ostracism of refugees in the national and international discourses. Despite a reversal of the 2012 cuts at the federal level in Canada, attention needs to be paid to making information about the Interim Federal Health coverage available to both healthcare providers and users.

BACKGROUND

The current “global refugee crisis” that the United Nations (UN) calls the worst since World War II poses challenges to Western healthcare professionals and institutions (Boehler and Pecanha, 2015). In many Western countries, the population of refugees and refugee claimants has risen and their health-status and psychosocial wellbeing is receiving increased attention (UNHCR 2014). Several studies have documented a high incidence of general health and mental health issues for refugee claimants (Kalt et al., 2013; Gerritsen et al., 2006; Grove & Zwi, 2006; Hobbs et al., 2002; Tribe, 2002; Sinnerbrink et al., 1995).

Health entitlements for refugee claimants vary across Western countries and are generally more limited than for refugees (Arie, 2015; Norredam, Mygind, & Krasnik, 2006). Access to healthcare for claimants is restricted through domestic policy and law, and it is often limited to emergency medical care and immunisation services (Langlois et al., 2016). Many Western countries adopted spending cuts to the healthcare sector in the aftermath of the 2008 financial crisis, generally increasing user fees and creating other difficulties in accessing care (Economou et al., 2016; McKee et al., 2012; Karanikolos et al., 2013) Specific cuts to refugee claimant healthcare has also been linked to anti-migrant “deterrence” policies (Martinez et al. 2015; Silove, Steel, & Watters, 2000).

Research consistently shows that refugee claimants tend to under-utilize psychological and other healthcare services in Western host countries and also delay seeking care (Ellis et al., 2010; De Anstiss et al., 2009; Laban et al., 2007). A number of barriers have been identified, including linguistic barriers, financial constraints and unemployment, cultural differences, and systemic legal/policy barriers, which limit the access claimants have to health services and related advocacy (Guruge & Butt, 2015; Asgary & Segar, 2011; McKeary & Newbold, 2010;

Berinstein et al., 2006; Sheikh-Mohammed et al., 2006; Murray & Skull, 2005). Evidence is limited, however, in regards to refugee claimants' own experiences of barriers to seeking healthcare in Western host countries.

The Interim Federal Health Program (IFHP)

The present research was conducted in the province of Quebec, Canada, during a period of heightened federal restrictions on refugee health coverage. Specifically, cuts were made on June 30, 2012 to the Interim Federal Health Program (IFHP), a federal insurance plan designed to cover certain groups, such as refugee claimants, who have yet to become eligible for provincial coverage. Between June 2012 and April 2016 there were significant reductions to Canadian federal health insurance for almost all categories of refugees, but especially for refugee claimants. The cuts were made in a context in which there were already pre-existing forms of inaccessibility for refugees and refugee claimants in the healthcare system (Barnes, 2013).

Subsequent to the IFHP cuts, most categories of refugee medications ceased to be covered except for conditions threatening public health or safety. Although medical services continued to be fully covered for most refugee claimants, those claimants from countries deemed safe by the Minister of Immigration (Designed Countries of Origin) and refused claimants lost all medical coverage except for public health and safety conditions. Prior to these cuts the IFHP was a much simpler, streamlined system of coverage in which all categories of refugee claimant and resettled refugees were offered the same basket of services. The new program reshuffled health coverage into eleven separate categories with differing degrees of entitlement to four baskets of services. Consequently, the program became far more complex and more difficult to implement (Ruiz-Casares et al., 2016).

Immediately, on the same day the cuts took effect, measures were instated by the province of Quebec to compensate for gaps in federal coverage for all refugee claimants and refused claimants with a valid Interim Federal Health (IFH) certificate. Consequently, claimants and refused claimants retained the same coverage as a person with Quebec health insurance (RAMQ) with very few exceptions (e.g. organ transplants). In addition, Quebec provided coverage for certain supplemental services such as rehabilitation and home care. The Quebec Ministry of Health explicitly prohibited physicians and health institutions from charging fees to patients with a valid IFH card, but nevertheless, access problems such as erroneous billings and/or outright refusals were still documented (Gérin et al., 2013). In a Montreal Gazette op-ed by Gérin and colleagues (2013), it was argued that the complexity of the IFHP after the cuts "lessens the concrete impact of Quebec's compensatory measures, especially as treating physicians shoulder the responsibility of deciphering the system". Thus, the fact that there was no official gap in legal entitlements in Quebec does not mean that the policy changes to the IFHP did not have a deleterious effect on refugee claimants.

Healthcare Barriers for Refugees in Canada

Cataloging and describing types of barriers to care facing refugees and refugee claimants, including policy/legal barriers, is a well documented area both in Canada, and in other Western countries (Campbell et al., 2014; Caulford, 2014; Balaam et al. 2016; Bozorgmehr, Schneider, & Joos, 2015; Szajna & Ward, 2015; Hadgkiss & Renzaho, 2014). A barrier to care is anything that makes it more difficult to access, utilize, and benefit from healthcare (Caulford, 2014). In Canada even before the cuts, the IFHP had some limitations including not covering certain prescription medications (Campbell et al., 2014). There are also challenges commonly faced by other groups as well, including language difficulties, long wait times, and delays in receiving care. The impact is magnified for refugee claimants, however, given their histories which may have included interactions with healthcare staff that participated in a system of oppression or torture in their home country (Crosby, 2013).

Barriers to care have been documented in the city of Montreal, where the present study is based (see Brabant & Raynauld, 2014). Studies looking into the impact of such barriers, however, are scarce. The studies that did touch on impacts tended not to explore the perspectives of health-users regarding their own lived experiences (Fang et al., 2015). Some studies are further limited by being based on the experience of a single institution or the perspectives of health practitioners solely (Evans et al., 2014; Rousseau et al., 2008). It is important to complement the observations of these health providers with perspectives from those who are directly affected, namely refugee claimants themselves.

Engaging with the Experiences of Refugee Claimants

Documenting and engaging with the subjective views and experiences of claimants can offer an important angle of vision to the issue of healthcare access barriers. This approach uniquely sheds light on how individuals' own views of their situation can impact their current and future wellbeing. Pollock and colleagues (2012) conducted interviews with claimants in Canada and discovered that some who felt intimidated or threatened in their interactions with healthcare workers avoided seeking out healthcare services all together. Putting claimant voices at the center of research also helps to ensure their status as research 'subjects' and not merely 'objects' (Jacobsen & Landou, 2003). In a special May 2016 issue of the journal *Refuge* that focuses on 'Refugee Voices', contributing authors address the silencing and "othering" of refugees and refugee claimants that occurs in research (Chatty, 2016). In focusing on the experiences of refugee claimants, descriptive data is generated that reveals a lot about their experiences and the problems they encounter (Jacobsen & Landou, 2003). Doná (2007) describes how these firsthand accounts contribute to the improvement of "programmes and policies", and it has been generally recognized that rich narratives are of great value in informing social and health policy (Bradley, Curry, & Devers, 2007; Robinson & Tolley, 2005; Ritchie & Spencer, 2002).

This study is guided by the following questions: How do refugee claimants describe and understand difficulties accessing healthcare in Montreal? What subjective experiences do they associate with these difficulties, and in what domains do they feel their lives have been most impacted? Of particular interest to this study are the possible ways in which claimants feel that difficulties accessing healthcare have affected them beyond physical health issues or psychological symptoms. In seeking to collect this breadth and depth of experiences, it is hoped that a wider understanding can be achieved about the experiences of refugee claimants interacting with the Quebec healthcare system in the city of Montreal. The term "claimant" will be used subsequently in this article in a way that is inclusive of both refugee claimants and refused claimants.

METHODS

Interviews with refugee claimants for this study were undertaken in 2014 and 2015 in the context of this documented gap between legal entitlement in Quebec and on-the-ground access to healthcare. The focus of these interviews was health-seeking trajectories and the impacts claimants felt had occurred as a result of healthcare access difficulties. Particular attention was given to barriers associated with the IFHP cuts and/or the noncompliance of healthcare staff with the Quebec Ministry of Health's instructions to provide care (which may be attributed to confusion or other causes).

Participants

A total of 31 refugees and refugee claimants participated in this study. Each of them had started in Canada as refugee claimants, rather than as resettled refugees, although some had been accepted as Convention refugees. Others had their claims rejected and were in the process of appealing these decisions, while still others had exhausted all of their appeals and remained in Canada under a stay of deportation (or moratorium). Participants originated from 21 different countries, mainly in Africa, the Middle East, and the Caribbean, with approximately one third coming from Congo, Democratic Republic of Congo, and Haiti. Participants were invited to participate if they were at least 18 years of age and if they had experienced difficulty accessing healthcare in Quebec since June 2012. Moreover, they had to have been a refugee claimant or refused claimant at the time of this initial difficulty. Posters and flyers with information about the study were distributed to selected health clinics, social service centers, and community organizations based in Montreal that frequently serve refugee claimants. English-language recruitment materials were translated into French, Spanish and Arabic to represent the four most spoken languages in Montreal (Stats Can, 2011). At each of these sites service providers were informed about the aims of the study. Service providers who agreed to participate were invited to inform eligible clients about the study and to make referrals. Additionally, a snowball sampling procedure was employed with participants by asking for names of other eligible and potentially interested individuals within their networks.

Data Collection

A qualitative approach is appropriate for research taking place within multicultural environments or that involves participants from a range of cultural backgrounds (Suzuki et al., 1999). As noted by Kirmayer (1989) as well as Lopez and Guarnaccia (2000), culture shapes the experience and expression of distress and social difficulties in multi-faceted ways. Creswell (2011) observes that qualitative research provides rich contextual data that "emphasize the voices of participants through quotes". Data were collected through in-depth, semi-structured interviews with refugee claimants lasting approximately one hour. Interviews were conducted at a primary care centre. Interested participants were first screened for eligibility over the phone by a research assistant. Interviews were conducted in English or French or in the participant's language of choice. An Arabic speaker assisted as an interpreter for four of the interviews. The interview protocol first required verification of eligibility and gathering of demographic information, followed by documenting incidences of problems accessing healthcare and trying to understand why they occurred. Next, participants were engaged about the ways in which they responded to these barriers, followed by the negative impacts on health and wellbeing that they perceived to have been related to access barriers. Finally, the general knowledge of participants about the health system was solicited, in conjunction with their opinions on barriers to care and ways to improve access as well as why this should be done.

Analysis

Recordings of each interview were transcribed verbatim. In cases where interviews were conducted in Arabic, the aforementioned interpreter also provided the transcriptions. Interview transcripts were analyzed by two individuals, myself and another graduate-level researcher at McGill. A preliminary reading of each transcript was first carried out by each of us, and disagreements, if any, were discussed in order to resolve discrepancies and establish inter-rater reliability. Parent codes were arrived at deductively based on the main topics of the interview guide (i.e. health problem, description of access problem, impact of access problem) and sub-codes were developed inductively through the preliminary readings of the transcripts and throughout the coding process (Bradley, Curry, & Devers, 2007). Parent codes and sub-codes were reviewed and refined through regular research team meetings (Weston et al., 2001). NVivo 10 (NVivo 2012) was used to perform a thematic content analysis on the transcripts.

Direct quotes are often provided in this manuscript to describe participants' own understandings and subjective experiences of healthcare access. There were, however, no means to independently verify participants' statements or their causal attributions. No systematic analysis was performed regarding country of origin and whether this influenced local healthcare experiences in Canada.

Ethics

Before the interview began participants were read an information sheet and asked if they would provide oral consent to continue and to be audio recorded. Consent for audio recording was given in all cases except for one, and extensive notes were taken by the interviewer in that instance. The protection of confidentiality was a high priority and participants were informed of the various measures taken including removing identifying details such as country of origin and dates from interview transcripts and storing all data in locked drawers and/or password-protected computer files. After the interview ended, all participants received an information sheet detailing their current entitlements to healthcare. In addition, two tickets for public transportation and a $25 gift card for a supermarket were provided. In several instances, permission was sought and received from the participant to provide referrals to service providers for care or further intervention. This study was approved through a multicentric ethics review process coordinated by the CSSS de la Montagne Research Ethics Board (REB) and the REB of the McGill University Health Centre.

RESULTS

Overview of Barriers

Many participants described their own health status, or that of their family members, as poor. In attempting to access healthcare, participants described many difficulties that some directly linked to their legal status, while others attributed more generally to the process of adapting to a new post-migration context. The main categories of access difficulty that emerged as they related to legal status were: 1) denials and/or delays of care despite being fully in coverage, 2) periods of coverage expiry, and 3) limitations in coverage.

In some ways the most problematic type of access difficulty was where claimants experienced refusals, erroneous billings, or delays in care despite having full legal entitlements. Leila, a middle-aged mother from Mali, discussed the anxiety she felt in relation to not getting care right away for her daughter: “She almost died of bowel obstruction. The record is there. So if I was seen by clinics where there was no refusal and everything, it would have been less complicated.” In a less dramatic but nonetheless still troubling situation, some claimants were apparently told they lacked coverage for blood tests.

One of the participants who experienced a period of coverage expiry was Moukhtar, a father from Lebanon. Moukhtar described his children were billed for medical visits and his wife was delayed in getting an appointment for complications from a miscarriage operation. Moukhtar had difficulties understanding both English and French, and did not understand that renewing his own IFH would not also cover his wife and children, as had been the case in Lebanon. According to Moukhtar, the resulting lapse in coverage contributed to many of his family’s troubles seeking healthcare, including fees and delays.

Coverage limitations also presented challenges for some claimants in our study. Noura, a young woman who escaped more than a decade of physical and sexual abuse in Saudi Arabia, talked about having to pay out-of-pocket for a type of depression medications that were not covered: “I know that anti-depressants are really expensive but they should allow more access…I did have a suicidal attempt. But I think I would have done it 10 times worse [without medication, $170 for 15 pills]”. Noura emphasised that she felt fortunate to have been able to afford these medications, but thought that other claimants with more restricted financial means would not have been able to access them at all.

Impacts of Access Difficulties

The following subsections outline in greater depth some of the physical health, mental health, financial, and sense of belonging impacts that participants reported experiencing.

a) Physical Health

Miguel, a man from Dominican Republic, came into the interview using crutches, the result of a work place injury. Miguel revealed that he had a heavy piece of machinery driven over two of the toes on his right foot, completely crushing them. He developed gangrene and had to have an amputation on his damaged toes and attributed this outcome to receiving sub-standard care. When asked about the lack of care he received, which he called neglect, he made it clear that it was linked to his legal status: “It is because I’m a refugee; that, I think, and maybe because I am a migrant. And they know when I didn’t offer the paper… they think I can’t sue them”. Though he wrote to the media about his healthcare experiences, he never received a reply.

Rahul, a diabetic man from India, was charged fees for insulin that he found very prohibitive: “They sent medical IDs to my babies, and to me and my wife. But we are not covered for the medications. I am diabetic, my total medicine is $136 every month”. He could not afford to take insulin for a period of two months, and some of the impacts that were described by he and his wife included “shaking and sweating”, uncontrollable fatigue, and falling asleep at unpredictable times: “I would be talking with you and just sleep”. Rahul specifically mentioned that this affected his ability to work or hold a job.

A woman from Pakistan named Rameen said she could not access prescription medications and attributed this to limitations in coverage. She told us she had to rely on inferior, over-the-counter painkillers for both herself and her son for most of their health complaints: **“**I buy the Uniprix medicine, pain killers, and morning and evening I take them. Me and my Uniprix is good [laughs], because the doctor is not available”. In regards to her eldest son, she said: “When he’s feeling sickness, I give the Tylenol medicine”.

b) Mental Health

For many claimants, the process of seeking healthcare was itself a major source of stress and anxiety. For some, like José from Dominican Republic, or Romara from St. Vincent, this relates to linguistic barriers. Romara said she went for care but left before being seen: “because I was there sitting and I couldn’t understand what they’re saying on the microphone or the nurses or anything. So then I left because it was just chaos in my head, I couldn’t understand what was going on”. In addition to having trouble reading information about his benefits, José told us that he felt frustration and despair after going for a long period in a waiting room without being seen: “they don’t really tell you directly but the way they act is…make you wait over-night and like more than other person, so they make you feel so uncomfortable that you give up”.

Delays to accessing mental health medications were sometimes perceived as uncaring and related to legal status. Thérèse, a woman from Burkina Faso, placed a call to a health clinic in Montreal to ask for anti-depressants, explaining that she was feeling suicidal and had already made one suicide attempt. She told us that “the moment when we called they said that it was not really urgent and you had to go on Tuesday or Thursday without an appointment”. Thérèse stated that the lack of urgency was probably because of her immigration status which she was asked to share with the clinic over the phone. Thérèse eventually received an appointment, but this was more than two weeks after her call and this caused her a great deal of distress.

c) Financial

Participants were sometimes refused or billed for medical visits and services to which they were entitled. Christopher, a man in his thirties from St. Vincent, had a sick child and was charged for a rash medication, supposedly because this child was not yet “added to the welfare stub”. Christopher reported that having to pay this unnecessary bill was “worrisome” for both himself and his wife as it “spread our dollars even more”. Yasmine, a woman in her mid-thirties from Algeria, was told at a clinic by a staff person that she could not get a consultation because her disease was not “contagious” and dangerous for the community. She said she was delayed in receiving care and had to eventually pay fees.

Financial barriers forced some participants into difficult choices. A few participants mentioned skipping meals as a means of freeing up money to cover medical expenses. Elodie, for instance, a woman in her thirties from Democratic Republic of the Congo (DRC) said that the amount for a medical bill “exceeded even the money [welfare gives]. So if I have to pay that, I am not going to pay even for my house, I am not even going to eat. And then I will still have a debt.”

Financial barriers to accessing care sometimes instilled hesitation to use health services at all. Dedou, a Haitian woman in her mid-thirties, was told in an initial visit to the doctor that there was a fee but that the money would be returned to her. When she sent her information to Régie de l'assurance maladie du Québec (Quebec provincial health insurance), she was told that she would not be reimbursed. This shook her faith in the fairness of the healthcare system. Subsequently, Dedou delayed getting a lung exam for her son. Although she heard she could get the lung exam and would get the money back, she did not go through with it because she did not trust that she would get reimbursed.

d) Sense of Belonging: Fear and Shame

Experiencing difficulties accessing various healthcare services at times induced fear or shame, sometimes both. Several participants who were mentioned in previous sections will again be featured here, as these experiences of feeling less-than and unwanted outsiders were so frequently mentioned. Roland, a Congolese (DRC) man in his forties, said: “You have not seen your family; you fled a situation that happened to you there. You are paranoid and have fear”. Régis, a 40-year-old man from Republic of the Congo, said that “Most asylum seekers here are always anxious. They’re afraid of getting sick”. According to Omar**,** the man from Algeria mentioned in a previous section, refugee claimants may be afraid of going to the hospital even if they possess a valid IFH card**.** Finally, a young mother from Yemen named Selam decided to have an abortion largely due to a story recounted by a friend who told her about having a bad healthcare experience. Selam told us: “It is so bad. I am scared because I do not want to give a baby here in Quebec. That's why I do abortion.”

Another frequently mentioned experience was feeling shame or feeling concerned about being stigmatized. For some participants, a sense of shame was linked to having their refugee claimant status involuntarily exposed to others; to others, these feelings were tied to more general perceptions of being discriminated against or not being treated as an equal member of society**.** Leila**,** the woman from Mali, told us about one such experience at her local health clinic:

"There were many people, this is my neighborhood, people I knew…I have not returned because I got humiliated…I saw people from my children's school." Solange, a woman from Cameroon who had trouble accessing medications, shared feelings of not belonging to Canadian society:

> "The impact for me was social. You know when you go to the drugstore and you can't take a medication and someone tells you 'No, you can't have this medication', you feel like you're not a part of the society. It's sort of like that. So, you feel isolated. Sometimes you feel ashamed but you don't have a choice."

Similar sentiments were echoed by Rameen and Omar**.** Rameen talked about feeling as though she does not have the same rights as other patients, while Omar worried his motives for seeking care would be questioned because of government rhetoric about 'bogus' claimants. These experiences of perceived exclusion or stigma can occur at the reception desk, waiting room, or even while a claimant is receiving treatment. As an example of the latter, Yasmine recalled an uncomfortable experience of being on a stretcher while a healthcare worker was loudly speaking about her lack of coverage.

In some cases, participants felt like the act of using the IFH paper itself stigmatized them and marked them as different in a negative way. Romara**,** the woman from St. Vincent, told us directly that: "A lot of people are ashamed to use this paper [IFH document]. A lot of people I knew, they would hide it, they don't want anybody to see them taking this paper." Romara went on to describe a friend with asthma who would try to hide the IFH document when seeking healthcare, or even sometimes not go at all rather than face the shame of exposure. Roland expressed that the IFH card implies an inferior status within the Canadian healthcare system vis-à-vis those with provincial insurance coverage: "I can't help seeing that it's special treatment," he said in regards to provincial health insurance cards, “because I saw people who came with their health cards, and they were treated as soon as they arrived.

DISCUSSION

The situation in Quebec during the study period made it a compelling context to explore healthcare access barriers for claimants. The IFHP cuts restructured health coverage federally but compensatory measures were in place at the provincial level in Quebec to fill in coverage gaps. Legal entitlement shifted very little on-paper, but access challenges on-the-ground were nevertheless frequently reported. Prior studies in Montreal and Toronto have shown that refugee claimants have been turned away from clinics in both Montreal and Toronto, despite being legally entitled to requested health services (Webster, 2015). Refugee claimants have faced similar types of barriers in the United Kingdom and Australia (Taylor, 2009; Davidson et al., 2004).

While the interview segments above point to remaining limitations in health coverage, as well as confusion and prejudices in health providers, what they most helpfully bring forward are the perspectives from claimants themselves on the impacts of negative healthcare experiences. As expressed by claimants, difficulties experienced while attempting to access healthcare resulted in physical, mental, and financial impacts, as well as feelings of not belonging. These latter feelings of exclusion, shame, and fear cannot be fully understood without consideration of certain national and international discourses that ostracize refugee claimants and create a context of suspicion. These discourses promote myths and stereotypes including that refugee claimants are ‘bogus’ or that claimants select host countries based on social benefits systems (Parker 2015; Gabrielatos, 2014; Esses, Medianu, & Lawson, 2013).

It is notable that experiencing any one of these impacts can affect health and wellbeing in a variety of ways. Mental health and emotional distress can lead to despair and distrust of the health system, and at its extreme, it may heighten suicidality. Findings here also support the observation of Gushulak and colleagues (2011) that economic deprivation and poverty, common in refugee claimant populations, can exacerbate health problems. Financial burdens can force those with already limited financial resources into making difficult choices, such as not eating to save money for medical expenses. Needing services that are out of coverage or being erroneously billed or refused can amount to not receiving that treatment at all, or being saddled with steep and sometimes unpayable bills. Finally, feelings of fear and shame commonly contributed to perceptions of being a social outsider and, in some instances, to participants wanting to avoid the health system altogether.

It must be underscored that the finding about perceived belongingness to society has hardly been discussed in the current literature on health barriers and their impacts on refugee claimants. One notable exception is Bhatia and Wallace (2007) who found that for claimants in the United Kingdom, subjective experiences of stigma can lead to reduced help-seeking. Chavez (2012) observed about refugees more broadly that not feeling a sense of belonging, or feeling disrespected by members of the host society, affects wellbeing. Bannerman, Hoa and Male (2003) specifically identified fear as a barrier to obtaining health services, although their focus was the uninsured. Each of those findings is reflected on some level in the experiences of refugee claimants in Montreal.

To better understand this theme of not belonging, it can be framed in terms of experiencing simultaneous invisibility and hypervisibility. The apparent paradox of these terms can be resolved through the distinction between being seen – visibility – and being watched –

hypervisibility. A crucial part of understanding claimant experiences may be an acknowledgment of this condition of being watched without being seen. Gilbert and Lo (2009) describe refugee claimants as “Others whose presence at the borders of the nation has been marked by both hypervisibility and invisibility and whose access to cross-cultural dialogue has been severely limited” (p. 189). Arendt has written on how for refugees an essential aspect of their predicament is the loss of a “place in a community” and “political status” (Arendt 1973, p.301) – in other words, invisibility. Refugee claimants in the present study sometimes felt ‘unseen’ through attempts to access healthcare that did not lead to treatment – that sometimes did not get past the reception desk.

The flip side of feeling unseen or invisible has been termed ‘hypervisibility’, which functions as a kind of unwanted exposure and scrutiny. Mercer (1999), an early theorist of ‘hypervisibility’, proposed it as a condition experienced by black migrants who are commodified in the art world for their ethnic identity. The term ‘hypervisibility’ has been used subsequently in reference to refugee claimants (see Tyler, 2006) as well as to migrant workers (see Lobo, 2015). According to Cancellieri and Ostanel (2015), the hallmark of ‘hypervisibility’ is that it is “visibility acquired by difference” (p. 507). Borren (2008) writes that refugee claimants, as precarious status individuals, are “devoid of both home and mask”. In other words, they are lacking a context that would render them more legible to members of the host society, while experiencing the vulnerability of not being able to hide from unwanted attention: the “disclosure of ‘who’ is replaced by the exposure of ‘what’” (Borren 2008, p. 225). This description of ‘hypervisibility’ captures especially well the narratives of participants in the present study who did not want to use their IFH cards. Perhaps this reluctance to use the IFH card is linked to a fear that their personal identities could be at risk of being replaced entirely by their legal identities,

identities that in some quarters have negative connotations of being ‘bogus’, ‘criminal’, ‘threatening’, or ‘opportunistic’ (Baker et al., 2008; Lynn & Lea, 2003).

Engaging with the first-hand narratives of claimants has great value. These perspectives fill gaps left in the literature, which engages primarily healthcare providers (Rousseau et al., 2008). That health provider perspectives have been largely centred in this literature is due, at least in part, to the fact that this data may be much easier to collect. When conducting health research with refugee claimants, there are many methodological and ethical challenges (Sulaiman-Hill & Thompson, 2011). Even compared with other vulnerable or marginalized populations, there may be important additional considerations for recruiting claimants as participants, for instance making a psychiatrist available (Ogilve, Burgess-Pinto & Caufield, 2008). There are also sometimes language barriers in conducting interviews with these populations that necessitate the hiring of translators and/or interpreters. Finally, Ogilve and colleagues (2008) observe that precarious legal status can generate a hesitancy to be interviewed, as there is understandable fear that disclosure of personal information will negatively influence ongoing refugee determination processes.

Limitations of this study should be noted. First, this study’s qualitative approach does not allow for generalization of impacts of healthcare access to other refugee claimants. Second, there is likely a sampling bias towards an inclusion of participants with above average levels of negative experience with the healthcare system, as a participation requirement was to have had some sort of difficulties accessing care. Third, information was only gathered from refugee claimants and highlights their perspectives alone - it cannot be taken as pointing to barriers in an ‘objective’ sense. If a participant stated that s/he received poor care due to migration status, for instance, the statement is presented to show the subjective experience of discrimination, but it does not necessarily mean that in actuality s/he received poor care, or that it was for this reason. Causal conclusions cannot be drawn.

CONCLUSION

The refugee claimants in this study reported facing a range of impacts from healthcare barriers. They were all residing in Montreal in the province of Quebec, which immediately put full compensatory funding in place to address the gaps in coverage left by the IFHP cuts. Building on prior research, this study foregrounds claimant experiences that point to consequences of barriers that related not only to physical and psychological health, but also to financial wellbeing and a sense of belonging. These other impacts, in turn, can affect health, primarily through diminished health-seeking. Indeed, claimants shared that they felt both fear and shame at times when accessing health services in the host society. This latter finding touches on a highly under-researched area.

The policy/legal barriers to accessing healthcare identified here can be viewed as one of the major hurdles to increased healthcare access. Nonetheless, even if the policy environment continues to improve, as it did when full IFHP coverage was reinstated across the country on April 1, 2016, there may still be access problems regarding benefit implementation and at the user-level. This area presents one of the greatest opportunities for constructive change, and more resources should be allocated, for instance, to making information about Interim Federal Health coverage available to both healthcare providers and to IFH card holders. The voices of refugee claimants captured here are clearly calling for greater attention to the health system as it stands and the ways that it is failing them. These calls for change should not be ignored.

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CONCLUSION

With the global refugee crisis as overarching context, these two papers explored related facets of the access challenges faced by refugee claimants navigating healthcare services in Canada. Canada has a tax-payer funded public healthcare system, and a question debated with particular fervor by Canadians in the past four years has been where to draw the lines around this coverage, particularly as this applies to refugee claimants. The Canadian public has evidently been divided on what health entitlements are owed to refugee claimants. While claimants are not full members of their host society – socially, politically, and legally – there are still those who contend that despite these exclusions, their experiences in the healthcare system should not be in any way compromised or intentionally degraded vis-à-vis other members of Canadian society.

In my first paper, I examined the rhetoric used by the federal Conservative government to justify significant cuts to refugee healthcare, comparing this with the rhetoric of a pan-Canadian alliance of doctor advocates that formed to challenge the cuts. I showed how the discursive stances of each of these parties can be characterized as frames, bogus and victim frames respectively. These frames were used in an effort to steer the debate and to mobilize members of the public. While both frames had their adopters, the victim frame appears to have been more persuasive and the advocacy of CDRC as a whole was highly successful. At the same time, I argued that the conversation was limited by featuring these two frames so prominently. Further, from an advocacy standpoint it is important to keep a critical gaze on advocacy frames, as they may have negative repercussions, intentional or otherwise. The deployment of victim discourse in this context can be read as "medical humanitarianism", a framework that positions healthcare provision to as charity, a tenuous grounding given swings in public opinion about "outsiders" ranging from fear to compassion. This use of a victim frame also risks homogenizing nuanced identities, Othering refugee claimants, and generating a constrictive burden of expectation to fit the ideal victim mold.

In my second paper, I opted for a closer-range level of analysis, focusing on claimants' own narratives in the context of navigating healthcare barriers in Montreal. While the first paper was more theoretical and studied national discourse around the IFHP cuts, the second was built around claimant interviews and examines the details of their experiences facing healthcare barriers and the often multi-faceted impacts of these barriers. I made a case for why studying this issue requires an engagement with claimants themselves, for the bulk of existing research is limited by being exclusively focused on health provider perspectives. Each point of view can offer valuable insight, although there will be certain dimensions of the topic that can only be captured from a health-user vantage point. Perhaps the most instructive theme that emerged from these interviews with claimants was that their sense of belonging, both to their local communities and to Canada, was negatively impacted by experiences – or at least perceptions – of being treated differently in the healthcare system. Differential treatment was frequently perceived as discrimination. Using the IFH card itself was experienced by some as bringing shame and as singling them out for stigma. These feelings are important elements to consider. Fear, shame, and a sense of exclusion were all reported as factors that influenced future health-seeking behaviour.

Before drawing these reflections to a close, I want to underscore that both of these papers endeavored to address the issue of silencing and marginalizing of refugee claimant voices. The first paper suggests that the Canada-wide debate about claimant healthcare was dominated by two privileged groups, one of which, the doctor advocates, clearly had the objective of promoting claimant interests but which could still only attempt to speak on their behalf. The second paper focused on a significant gap in the literature, which was a paucity of first-hand perspectives from claimants. In doing so, it offered a channel for expressing to a group that is unfortunately rarely heard. As a final reflection, then, it is important for us to acknowledge this: refugee claimants do have a voice. It is incumbent upon us to listen.

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