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Barriers to Belonging: Navigating Approaches to Protecting Refugees' Access to Healthcare in Canada

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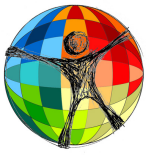

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ABSTRACT

Access to quality and equitable healthcare for refugees and precarious status migrants is a pressing issue internationally. Upon arrival in Canada, refugees face significant political, legal, and financial barriers that hinder access to care. A legacy of structural discrimination and restrictive healthcare policies continues to impact Canada's responses to the healthcare realities of those who seek refuge within its borders. This paper explores the lived experiences of refugees, refugee claimants, and healthcare providers to highlight disparities in access to and provision of care under the current federal framework. The paper delves into legal methods that have been employed to bolster access to healthcare. These approaches include invoking the Canadian Charter, ratifying international obligations, and constitutionalizing a right to health. However, barriers inherent to the use of legal approaches risk deterring refugees from seeking just health outcomes. The paper then discusses alternative methods to allow for leveraging of refugee voices through participation-based advocacy and Amartya Sen's capability approach. These methods have the potential to enable refugees to implicate themselves in the processes that construct their identity and well-being. Ultimately, sustainable refugee healthcare reform must center on meaningful engagement and empowerment of those whose lives are directly impacted by a host society's variable policies.

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Introduction[1]

Canada has conditionally pledged to provide healthcare to all within its borders. The *Canada Health Act* ("CHA") purports to uphold the universality and accessibility[2] of healthcare with its main objective to "protect, promote and restore the physical and mental well-being of residents[3] of Canada to facilitate reasonable access to health services."[4] Yet the terms of universality and accessibility fail to be applicable to non-status individuals, and are only meaningful for those with legal status whose lives are "protected and valued" under the CHA.[5] As such, refugees and refugee claimants among others (e.g. temporary foreign workers, rejected refugee claimants, asylum seekers, and temporary residents) are denied access to the same level of healthcare due to their precarious immigration status.[6]

Since 1957, Canada has recognized a humanitarian duty of limited healthcare provision to refugees and refugee claimants under the Interim Federal Health Program ("IFHP"). This duty has been confirmed by international human rights treaties that recognize the right to health for all, including non-citizens. Despite international obligations to uphold the right to health, such a right is not expressly recognized or rendered enforceable in Canada. As a result, refugee healthcare in Canada is construed as a

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[1] The author would like to thank Kayla Miguéz for her assistance and guidance on the structure and content of this paper through her work entitled "Approaches to Strengthening Access to Healthcare in a Rural British Columbia Context: Harnessing Voice and Lived-Experience" (2019) *McGill Centre for Human Rights and Legal Pluralism* International Human Rights Internship Working Paper vol 8, online: *CHRLP* < https://www.mcgill.ca/humanrights/clinical/internships/working-paper-series>.

[2] *Canada Health Act*, RSC 1985, c C-6, s 7 [*CHA*], online: *Government of Canada* <http://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html>.

[3] *CHA* at s. 2 defines residents as follows: "in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

[4] *Ibid* at s 3.

[5] Tehmina Naseem, *Access to Healthcare for Precarious Immigration Status Persons: Human First, Status Later* (Master's Thesis, Ryerson University Centre for Immigration and Settlement, 2016) [unpublished] at 15.

[6] *Ibid* at 1. See also Zoé Brabant & Marie-France Raynault, "Health Situation of Migrants with Precarious Status: Review of the Literature and Implications for the Canadian Context–Part A" (2012) 27:4 Social Work in Public Health 330 at 336-339.

humanitarian obligation or privilege instead of a right.[7] Accordingly, access to equitable care continues to be implicitly framed in terms of "deservingness" and value based on status.[8]

When refugees and refugee claimants first arrive on Canadian soil, immense social, legal and bureaucratic challenges await them. Refugee populations are particularly vulnerable and face systemic barriers that impede access to healthcare. To this end, the paper will discuss refugees' and claimants' access to healthcare in Canada and their lived experiences within urban regions of Ontario. The paper will then identify pertinent legislative mechanisms as potential remedies to the challenges faced by refugees and healthcare service providers alike. Lastly, the paper will explore non-legislative vectors, in particular, leveraging community voice and legal empowerment as a stimulus for health policy reform.[9] The paper concludes that substantive improvements to the healthcare realities of Canada's non-citizens must be rooted in a community-centered, capability approach that both empowers and mobilizes refugee voices.

Problematizing the Refugee Health Care Framework in Canada

Context and Definitions

Forced migration is increasing globally as human rights violations and protracted violence persist.[10] By the end of 2019, the United Nations High Commissioner for Refugees ("UNHCR") reported that 79.5 million people were displaced worldwide, with 26 million of these migrants considered refugees.[11] In the last decade, Canada has been at the forefront of welcoming and receiving refugees, ranking first among 26 countries in 2019 and

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[7] Vanessa Abban, "Getting it Right: What Does the Right to Health Mean for Canadians?" (2015) The Wellesley Institute 1 at 1.
[8] *Supra* note 5 at 18.
[9] Kayla Miguéz, "Approaches to Strengthening Access to Healthcare in a Rural British Columbia Context: Harnessing Voice and Lived-Experience" (2019) *McGill Centre for Human Rights and Legal Pluralism* International Human Rights Internship Working Paper vol 8 at 7.
[10] *United Nations High Commissioner for Refugees*, "Global Trends: Forced Displacement in 2019," online: *UNHCR.org* <https://www.unhcr.org/statistics/unhcrstats/5ee200e37/unhcr-global-trends-2019.html>.
[11] *United Nations High Commissioner for Refugees*, "Figures at a Glance" online: *UNHCR.org* <https://www.unhcr.org/figures-at-a-glance.html>.

resettling over one million refugees since 1980.[12] However, a legacy of restrictive policy practices continues to impact the resettlement of refugees in Canada today.[13] In August 2018, the United Nations Human Rights Committee reported that the Canadian government was falling short of providing adequate health care to refugees, immigrants and temporary foreign workers, ruling on a review of legislation to ensure timely access to essential healthcare "to prevent a reasonably foreseeable risk that can result in loss of life."[14]

Healthcare provision to refugees and claimants is a pressing issue internationally, given the unique needs of this population.[15] It is widely documented how refugees experience poorer health due to experiences of displacement and the resettlement process. Refugees may experience the trauma of war, family separation, physical and psychological torture; undergo prolonged stays in overcrowded refugee camps; experience severe resource deprivation; and have limited pre-departure access to health care.[16] The compounding effects of these experiences can critically undermine physical, mental and social health. Rates of anxiety, depression and poor well-being among this population are three times more severe than the host society's population.[17] Furthermore, refugees face significant barriers upon arrival in a host society such as unemployment, social exclusion, language difficulties, and limited knowledge of social services to assist in the resettlement process.[18] As such,

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[12] *Ibid*; see also *United Nations High Commissioner for Refugees*, "Refugee Statistics in Canada," online: *UNHCR.ca* < https://www.unhcr.ca/in-canada/refugee-statistics/>.

[13] Valentina Antonipillai et al., "Health Inequity and "Restoring Fairness" through Canadian Policy Health Reforms: A Literature Review" (2018) 20:1 J Immigrant Minority Health 203 at 203.

[14] Kevin Spurgaitis, "Why is Canada's Refugee Health Still Falling Short?" online: *Rehab Magazine* <https://www.rehabmagazine.ca/opinion/why-is-canadas-refugee-health-care-still-falling-short/>.

[15] Ibrahim Abubakar & Alimuddin Zumla, "Universal Health Coverage for Refugees and Migrants in the Twenty-First Century" (2018) 16:216 BMC Medicine 1 at 1.

[16] Sonal Marwah, "Refugee Health Care Cuts in Canada: System Level Costs, Risks and Responses" (2014) Wellesley Institute 1 at 4.

[17] OECD, Migration Policy Debates, *How resilient were OECD health care systems during the "refugee crisis?"* (Paris: OECD, 2018) No 17, online: *OECD* <https://www.oecd.org/migration/Migration-Policy-Debates-Nov2018-How-resilient-were-OECD-health-care-systems-during-the-refugee-crisis.pdf> at 1.

[18] *Ibid*.

provision of and access to quality healthcare is a critical first step to meet the needs of refugees and claimants.

For the purposes of this paper, the term 'precarious immigration status' refers to individuals residing in Canada without 'full' legal status which is capable of being revoked. This entails absence of permanent residence, lack of work authorization, third party dependency for residence or employment rights, restricted or no access to public services and protections available to permanent residents (e.g. healthcare, education, workplace rights), and risk of deportability.[19] Refugees in Canada are defined as protected persons who meet the international definition articulated in the 1951 Convention relating to the Status of Refugees ("Convention").[20] The term refugee claimant is used to describe who have fled their country and are seeking protection in Canada. Refugee claimants receive a decision from the Refugee Protection Division of the Immigration and Refugee Board ("IRB") on whether they are refugees after their arrival in Canada.[21] Claims are deemed ineligible if the claimant has made a previous refugee claim in Canada, has refugee status in another country or is inadmissible on grounds of criminality and security, among other factors.[22] Resettled refugees refer to individuals who have fled their country, are temporarily in a second country and are offered a permanent home in a third

[19] York University, "Precarious non-citizenship status," online: *YorkU.ca* <http://www.yorku.ca/raps1/popups/precarious.html>. See also Luin Goldring, Carolina Berinstein & Judith K. Bernhard, "Institutionalizing precarious migratory status in Canada, Citizenship Studies" (2009) 13:3 Citizenship Studies 239-265.

[20] A Convention refugee is defined as one "who is outside his or her home country and who has a well-founded fear of being persecuted for reasons of race, religion, nationality and membership of a particular social group or political opinion." See *Convention and Protocol Relating to the Status of Refugees*, 28 July 1951, (entered into force 22 April 1954) online: *UNHCR* <http://www.unhcr.org/3b66c2aa10.html> [Convention].

[21] Canadian Council for Refugees, "Background Information about Refugees" online: *CCR* <https://ccrweb.ca/en/information-refugees>.

[22] Immigration, Refugees and Citizenship Canada, "Terms and definitions relating to refugee protection" online: *Government of Canada* <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/refugee-protection/terms-definitions-related-refugee-protection.html>. See also *Immigration and Refugee Protection Act* SC 2001 c 27, online: *Government of Canada* <https://laws.justice.gc.ca/eng/acts/i-2.5/>.

country.[23] The Canadian government deems these individuals refugees prior to their arrival in Canada.

Social Construction of "the Refugee" in Canada

Beyond statutory definitions, Canada's socially constructed image of "the refugee" has been shaped by the current discourse on refugee policies. Refugees are depicted as the 'Other' and simultaneously construed as an "object of charity and as a threat to host countries."[24] The IFHP and its policy reforms are underpinned by a one-dimensional construction of "the refugee" burdensome and vulnerable, which deprives them of full integration into the Canadian population.[25] In essence, the term 'refugee' does not denote a fixed identity or essential state of being but refers to a social construct of noncitizens who experience persecution and precarious legal status.[26] However, refugee policies and migrant classification are predicated on an "us" and "them" distinction which perpetuates Othering of "the refugee." The notion of citizenship as "a collection of rights and obligations which give individuals a formal legal identity"[27] is articulated by dominant groups and emerges in direct opposition to those who are deemed "strangers, outsiders and aliens."[28] Qualities and stereotypes attributed to dominated groups are viewed as the worst attributes of the dominant group.[29] Accordingly, citizenship as an identity works to configure access to cherished societal resources such as healthcare. As an evolving concept, citizenship serves to interrupt refugee access to rights

[23] Resettled refugees also include government assisted refugees, individuals identified through the UNHCR and provided government support upon arrival to Canada and privately sponsored refugees who receive support from family members, churches, private individuals or non-governmental organizations; see Refugee Health Vancouver, "Refugee Categories" online: *Refugeehealth.ca* <https://www.refugeehealth.ca/refugee-categories>.

[24] Christopher Olsen et al., ""Other" Troubles: Deconstructing Perceptions and Changing Responses to Refugees in Canada" (2016) 18 J Immigrant Minority Health 58 at 58.

[25] *Ibid* at 59.

[26] Laura Connoy, "(Re)Constructing and Resisting Irregularity: (Non)citizenship, Canada's Interim Federal Health Program, and Access to Healthcare" (2019) 13:2 Studies in Social Justice 201 at 202.

[27] Bryan S.Turner, "Citizenship studies: A general theory" (1997) 1:1 Citizenship Studies 5 at 5-7.

[28] Connoy, *supra* note 26 at 204; see also Engin Fahri Isin, *Being political: Genealogies of Citizenship*, (Minneapolis: University of Minnesota Press, 2002).

[29] Connoy, *supra* note 26 at 209, 212.

while maintaining solidarity among citizens over time.[30] Construction of "the refugee" can work to bolster the exclusivity of citizenship at the expense of legitimizing unequal treatment and stigmatizing identities.

On a macro scale, othering of "the refugee" can also serve to construct the national identities of wealthy countries in the global North. Canada has long prided itself in a national identity framed by overarching principles of universal healthcare, social justice and equity.[31] However, the national self-images of host countries such as Canada depend on the existence of "the refugee" as the hapless and vulnerable other. Refugee resettlement is deemed a shared international responsibility and states are not legally required to receive refugees under the Convention.[32] As such, a host country's resettlement of refugees can be construed as an act of humanitarianism and benevolence. Host countries exercise and maintain a symbolic power differential in relation to refugees as their beneficiaries. This power differential disempowers refugees, rendering them unwilling to challenge inequalities within the system when gratitude is expected, if not demanded.[33]

Furthermore, media depictions of "the refugee" reproduce and repurpose the view of refugees as a threat. Depicting the arrival of refugees as a "refugee crisis" reinforced the perception that refugees represented an invasion on society.[34] Construction of refugees as illegitimate and suspect has emerged in discriminatory healthcare policies. In 2012, Minister Jason Kenney commented that the IFHP reforms would "stop the abuse of Canada's generous and overburdened healthcare system by bogus refugees."[35] Fear of the 'bogus' refugee created a classification system predicated on the notion of the 'genuine' refugee as vulnerable and helpless. To this end, exposing how refugees are constructed as the 'Other' is likely essential to

[30] Engin Fahri Isin, *Being political: Genealogies of Citizenship*, (Minneapolis: University of Minnesota Press, 2002) at 25-26, 49 cited in Connoy, *supra* note 26 at 205.
[31] Olsen, *supra* note 24 at 59.
[32] *Ibid* at 62.
[33] *Ibid*.
[34] *Ibid* at 63.
[35] *Ibid* at 60. See also CTV News, "Tories aim to fix "broken" immigration system" (2012), online: *CTVnews.ca* <https://www.ctvnews.ca/tories-aim-to-fix-broken-immigration-system-1.769664>.

dismantling systemic barriers to equitable treatment of refugees in Canada.[36]

What is the Situation in Canada?

The Interim Federal Health Program

While healthcare is primarily a provincial power, the federal government retains constitutional responsibility for the provision of healthcare to First Nations, military personnel, Convention refugees and claimants.[37] Introduced in 1957 after Canada's agreement to the Convention, the IFHP covers essential preventative and emergency care for eligible non-citizens. Basic coverage involves similar coverage rendered by provincial and territorial health plans, including laboratory and diagnostic services, although the benefits differ.[38] Supplemental coverage includes limited vision and dental care, access to clinical psychologists/speech language therapists, home and long-term care equipment (i.e. insulin, hearing aids), physiotherapy and some prescription drug coverage.[39] Coverage ends when refugees become eligible for provincial or territorial insurance.[40]

A Legacy of Cuts

Between 2012 and 2016, the IFHP sustained significant cuts, which despite full restoration of the program in 2016, continue to hinder refugee access to healthcare. In 2012, the federal government adopted two orders-in-council modifying who

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[36] Olsen, *supra* note 24 at 58.
[37] Richard Enns et al., "Refugee Healthcare in Canada: Responses to the 2012 Changes to the Interim Federal Health Program" (2017) 3:1 International Journal of Migration and Border Studies 24 at 27.
[38] Naseem, *supra* note 5 at 18. See also Citizenship and Immigration Canada, "Interim Federal Health Program Policy" (2016) online: *Government of Canada* <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/interim-federal-health-program-policy.html>. See also Immigration, Refugees and Citizenship Canada, "Interim Federal Health Program: Summary of Coverage" online: *Government of Canada* <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/help-within-canada/health-care/interim-federal-health-program/coverage-summary.html>.
[39] *Ibid*.
[40] CBC News, "Liberal government fully restores refugee health care program" (18 Feb 2016), online: *CBC* <https://www.cbc.ca/news/politics/mcallum-philpott-interim-federal-health-program-refugees-1.3453397>.

is eligible to receive care under IFHP and denying coverage for certain individuals.[41] These amendments purported to curb public spending, ensure fairness for Canadians, and protect against filing of "bogus" refugee claims.[42] In essence, the *Protecting Canada's Immigration System Act* created a three-tiered system that subjected individuals to differential treatment according to their country of origin, status of claim, and source of sponsorship.[43] Following the 2012 amendments, the IFHP was transformed into a vastly restricted, hierarchical health insurance system.[44]

The reformed IFHP introduced different types of healthcare coverage: expanded, basic and public health and public safety coverage ("PHPS"). Only a small proportion of refugees, namely government-assisted/privately sponsored refugees and victims of human trafficking, qualified for the "expanded healthcare coverage" which was previously available to all refugees and refugee claimants. The second tier, "healthcare coverage", provided basic services to refugee claimants who are not from designated countries of origin ("DCOs").[45] Such countries are deemed "safe" and unlikely to produce "genuine refugees" given the fact that they respect human rights and offer state protection.[46] Non-designated countries of origin are not considered safe for

[41] Yin Yuan Chen, Vanessa Gruben & Jamie Liew, "A Legacy of Confusion: An Exploratory Study of Service Provision under the Reinstated Interim Federal Health Program" (2018) 34:2 Canada's Journal on Refugees 94 at 95. See also *Order Respecting the Interim Federal Health Program*, 2012 online: *Government of Canada* <https://laws-lois.justice.gc.ca/eng/regulations/SI-2012-26/FullText.html>; *Order Amending the Order Respecting the Interim Federal Health Program*, SI/2012-49, (2012), online: *Canada Gazette* <http://canadagazette.gc.ca/rp-pr/p2/2012/2012-07-18/html/si-tr49-eng.html>.

[42] Government of Canada, "Reform of the Interim Federal Health Program Ensures Fairness, Protects Public Health and Safety" (2012) online: *Canada.ca* <https://www.canada.ca/en/news/archive/2012/04/reform-interim-federalhealth-program-ensures-fairness-protects-public-healthsafety.html>.

[43] *Protecting Canada's Immigration System Act*, SC 2012, c 17, online: *Government of Canada* <https://laws-lois.justice.gc.ca/eng/annualstatutes/2012_17/page-1.html>.

[44] Helen P. Harris and Daniyal Zuberi, "Harming Refuge and Canadian Health: Negative Consequences of Recent Reforms to Canada's Interim Federal Health Program" (2015) 16:4 *Journal of International Migration and Integration* 1041 at 1043.

[45] *Ibid*.

[46] Connoy, *supra* note 26 at 208.; see also *Chen et al.*, *supra* note 41 at 95.

return by refugees.[47] Refugees from DCOs undergo expedited hearing processes, but are barred from appealing failed claims and are delayed in invoking humanitarian and compassionate grounds.[48] Individuals in this category received only care deemed "essential or urgent" in nature which did not include long term care or services provided by professionals other than doctors.[49] The most restricted coverage, known as PHPS, only provided health services to those with failed refugee claims and those from DCOs whose conditions are considered to be a "threat" to public health and safety.[50] Notably, pregnant women in this category could no longer access publicly funded maternity services and individuals with mental illnesses could not receive care unless they were deemed to pose a threat to the public.[51]

Impacts of the 2012 Reforms

As a result of the reforms, all IFHP beneficiaries, with the exception of government-assisted resettled refugees, victims of human trafficking and immigration detainees, lost significant healthcare coverage. Critics noted that cuts to the IFHP signaled "a deep change in the way in which human beings are assigned value."[52] Health and wellbeing of refugee claimants only merited attention when the health and safety of Canadian citizens was impacted. Such an approach dehumanized the refugee by considering these human beings as a 'risk factor' for others.[53] The added complexity and stratification of the 2012 IFHP compounded difficulties in navigating the system for refugees, refugee claimants, and healthcare professionals. Prior to 2012, healthcare professionals already denied care to refugees given a lack of understanding of the program and its onerous reimbursement process.[54] Denials were further compounded by administrative delays, confusion in determining eligibility, and vague guidelines provided to healthcare providers by the federal

[47] Valentina Antonipillai et al. "Impacts of the Interim Federal Health Program reforms: A stakeholder analysis of barriers to health care access and provision for refugees" (2017) 108:4 Canadian Journal of Public Health 435 at 438 [Antonipillai 2017].
[48] Harris & Zuberi, *supra* note 44 at 1042.
[49] Chen et al., *supra* note 41 at 95.
[50] Harris & Zuberi, *supra* note 44 at 1044.
[51] Chen et al., supra note 41 at 96.
[52] Danyaal Raza et al., "A moral duty: why Canada's cuts to refugee health must be reversed" (2012) 58:7 Canadian Family Physician 728 at 728.
[53] Connoy, *supra* note 26 at 208.
[54] Chen et al., *supra* note 41 at 96.

government.[55] Overall, the 2012 IFHP reforms marginalized an already vulnerable population.

The 2014 Charter Challenge: Unintended Consequences

The reforms evoked significant collective outcry and advocacy efforts from Canadian health professionals.[56] In response to the cuts, a court challenge was launched against the federal government by the Canadian Doctors for Refugee Care, the Canadian Association for Refugee Lawyers and two refugee claimants.[57] In 2014, Justice MacTavish of the Federal Court ruled that the reforms violated section 12 (i.e. "cruel and unusual" treatment) and section 15 (i.e. discrimination based on country of origin) of the *Canadian Charter of Rights and Freedoms* ("Charter").[58] The court issued a suspended declaration of invalidity, allowing the government to amend the measures within a four-month timeline. The government restored essential PHPS services for all claimants regardless of country of origin[59] but added six categories of health coverage, instead of the initial three.[60] As such, the 2014 temporary reforms exacerbated existing barriers and created additional barriers to access and provision of health care, described by one doctor as a "complex matrix of impenetrable and incomprehensible degrees of coverage.[61] Anti-refugee political discourse and increased financial strain on the program further undermined refugee access to health care. The 2012 and 2014 reforms shifted the financial burden from the federal government to the provincial government, creating a legacy of administrative difficulties, bureaucratic inefficiencies and confusion.[62]

The 2016 Reinstatement: Ongoing Disparities

In 2016, IFHP was restored to its pre-2012 form, which entailed access to preventative care, essential medications and

[55] Connoy, *supra* note 26 at 209. See also Steve Barnes, "The Real Cost of Cutting the Interim Federal Health Program" (2013) Wellesley Institute Policy Paper at 6.
[56] Harris & Zuberi, *supra* note 44 at 1044.
[57] *Canadian Doctors for Refugee Care et al. v Canada (Attorney General)*, 2014 FC 651 [*CRDC*].
[58] *Ibid* at 1045.
[59] Connoy, *supra* note 26 at 210.
[60] Antonipillai 2017, *supra* note 47 at 436.
[61] Connoy, *supra* note 26 at 210.
[62] Antonipillai 2017, *supra* note 47 at 440.

services, including mental health care.[63] However, little is known on how well the reinstated IFHP is fulfilling its mandate to meet the health and safety needs of its beneficiaries. There exists a gap in the literature as to whether the consequences endured by refugee populations that pre-date the 2012 and 2014 reforms have resurfaced.[64] Refugee access to healthcare and provision of essential services is fraught with challenges even in host countries that build humanitarianism into their national identities, like Canada.[65] This paper acknowledges that health realities of refugees vary substantially across Canada, given the diversity in language barriers, proximity to urban centers, level of community support, cultural practices among other socioeconomic and demographic factors.[66] Corresponding strategies to improve refugee access to healthcare and empower refugees and service providers are by no means uniform.[67] As such, this paper does not seek to essentialize the refugee experience across Canada but focuses on the voices of refugees, refugee claimants, and health service providers residing in urban Ontario.

The Healthcare Realities of Refugees in Urban Centers of Ontario

The Lived-Experiences of Refugees and Services Providers

Numerous studies have identified that the multiple cuts and reforms to the IFHP have created complicated and inequitable health care coverage for this population. However, since the 2016 IFHP reinstatement, the first-hand experiences of refugees navigating access to healthcare have garnered little attention.[68] As well, the perspectives of supplementary healthcare providers such as dentists, optometrists have been left largely unaddressed. To understand these perspectives, I joined a team at the University of Ottawa that has been conducting a study on the experiences of refugees, claimants and service providers with the reinstated

[63] Harris & Zuberi, *supra* note 44 at 1047.
[64] Chen et al., *supra* note 41 at 96; Antonipillai 2017, *supra* note 47 at 440.
[65] Olsen et al., *supra* note 24 at 61.
[66] Bruce Newbold et al., "Access to Health Care: The Experiences of Refugee and Refugee Claimant Women in Hamilton, Ontario" (2013) 11:4 Journal of Immigrant & Refugee Studies 431 at 434.
[67] Miguéz, *supra* note 9 at 11.
[68] YY Brandon Chen, "Refugees once again have full health benefits, but some practitioners still don't know that" (2017) online: CBC <https://www.cbc.ca/news/opinion/refugee-health-care-1.4105120>.

IFHP. The candidness of the participants combined with the personal nature of the interviews provided for a holistic understanding of issues inherent to the IFHP. While the interview data is still being analyzed by the research team, key highlights of the study based on my own perspective are presented below.

Protecting Refugees' Health: How is the Reinstated Interim Federal Health Program Working?

An exploratory study on the Interim Federal Health Program conducted at the Centre for Health Law, Policy and Ethics at the University of Ottawa

Research Methods

The goal of the study was to collaborate with members of the refugee community and health service providers to gather evidence on their experiences with IFHP, with the aim of informing policymakers of potential strategies to improve refugee healthcare access and delivery. Refugees and claimants were invited to share their experiences on moving to Canada, their health needs, and accessing health services under the IFHP. The following section demonstrates the results of 20 semi-structured qualitative interviews conducted between 2018 to 2020 with refugees and refugee claimants in Ottawa and Toronto. These results are integrated with data gathered from 20 semi-structured interviews conducted with service providers who work with refugees and claimants in various health contexts (i.e. dentists, optometrists, nurse practitioners, community healthcare navigators, and occupational therapists). Interviewees were recruited through purposeful sampling.[69] Qualitative analysis of the interview transcripts revealed common themes.[70]

Gaps in IFHP Entitlement[71]

Interviewees identified gaps within the reinstated IFHP that continue to hinder refugee access to healthcare. Claimants expressed concern over the inadequate coverage for dental treatment and their inability to pay. One nurse practitioner deemed the state of coverage "abysmal" given IFHP covers only the cost of tooth extractions in emergency situations. Preventative care such as basic cleanings, cavity fillings, and root canal treatments are precluded from coverage. This results in service providers absorbing steep costs out of pocket in order to fulfill their ethical responsibilities to the patients.

Language barriers render access to care inequitable. IFHP covers only the cost of interpretation and translation for mental health services or post-arrival health assessments (for resettled refugees only). The steep costs associated with hiring interpreters can deter access to and provision of healthcare. A nurse practitioner recounted that there was a time "earlier on in [our] clinic's life we were spending more money annually on interpretation than we were on healthcare staff." Regarding IFHP, a care coordinator stated, "Not

having interpretation funded through the program seems again, like giving someone a gift they can't open."

Coverage for mental health was further deemed a weakness. IFHP covers psychotherapy and counseling provided by clinical psychologists and therapists.[72] However, one care coordinator noted that this coverage does not extend to specialized treatment such as trauma informed counselling and eye movement desensitization and reprocessing which may be particularly vital to refugees. Counselling services provided by social workers registered with the *Canadian Mental Health Association* ("CMHA") or nurses are not included within the scope of the IFHP. A nurse practitioner explained that an embedded CMHA social worker at her clinic volunteers to provide pro bono trauma counselling to clients. This gap in coverage should be amended to alleviate the burden on certified social workers and the long waiting lists.[73]

Ongoing Confusion about IFHP

Compounded complexity and confusion surrounding the IFHP stems from a lack of accessible and coherent information for both patients and service providers. One physician noted the 2012 cuts and 2014 temporary reinstatement exacerbated existing barriers that led to service providers to opt out of the system.

The majority of clients and providers said they were unsure of the eligibility criteria and the extent of service coverage of the IFHP. One claimant recounted an incident where a walk-in clinic refused to treat his pregnant wife who had a valid IFHP certificate. Others cited delays and difficulties in clinical confirmation of their IFHP coverage when in need of pressing medical treatment (e.g. insulin medication). Several community navigators cited difficulties in finding family physicians that accept IFHP clients.

Both clients and providers stressed the need for better education and accountability for services rendered. Claimants expressed a general lack of knowledge surrounding the IFHP among the refugee community. This is further exacerbated by a lack of support or clarification for refugees and social workers who contact Medavie Blue Cross ("Medavie"), the insurance company contracted by the government to administer IFHP. The insurance company only

[69] Martin N. Marshall, "Sampling for Qualitative Research" (1996) 13:6 Family Practice 522 at 523.
[70] Chen et al., *supra* note 41 at 96.
[71] Chen et al., *supra* note 41 at 95.
[72] *Ibid* at 97.
[73] *Ibid* at 97.

responds to inquiries from providers registered with IFHP with a valid ID. Service providers pointed to the lack of centralized, updated and user-friendly benefit grids, which detail services covered by the IFHP. They encountered interpretive challenges and one pharmacist noted that it was a trial and error process to confirm if a medication is covered. One physician observed that the opt-in system for providers resulted in subtle structural discrimination and emphasized the need for accountability measures to ensure that providers accept all forms of coverage.

Administrative Hurdles

Providers drew attention to the cumbersome administrative consequences of providing care through the program. After registration with Medavie, providers must obtain pre-approval of services and products prior to delivery. However, the delays within the pre-approval process can be excessive and costly. One community health worker recounted an incident where an elderly IFHP client had to wait nine months between major dental procedures in order for a clinic to obtain clarification on the approval and billing processes.

Service providers and clients alike described the reimbursement process as problematic. Denial of reimbursement can deter even IFHP holders from seeking care. One refugee recounted an instance where her gynecologist's office informed her after the fact that the federal government did not reimburse them for maternity care she received as a claimant. She described feeling deeply embarrassed, indebted, and even discouraged from attending future appointments.

Providers cited increased overhead costs with the onerous administrative process. Several dentists revealed that the approval process for treatments appeared arbitrary and inconsistent, recounting one incident where coverage was denied based on a minor difference in the materials used for a basic procedure. However, several optometrists and pharmacists recounted seamless experiences with the reimbursement process and helpful consultations with Medavie. These diverging narratives suggest inconsistent reimbursement practices under the current IFHP regime.

The Government of Canada's Response to the Issue of Refugee Healthcare

Clients and providers alike point to the persistence of challenges post-reinstatement of the IFHP. Sadly, laws and policies that entrench refugee healthcare rights and obligations do not necessarily translate to their equitable access to such services. Instead, the effects of a discourse of securitization, which justifies the differential treatment of non-citizens and denial of care to some of them, linger still.[74] Recent government efforts to improve refuge access to care have largely been financial in nature with minimal follow-up or accountability. In the 2019-20 budget, the government increased funding to $125 million and another $158 million in 2020-21 to "promote better health outcomes for both Canadians and those seeking asylum in Canada."[75] However neither the recent Health Canada Departmental Plan nor the 2020 Annual Report to Parliament on Immigration detailed tangible outcomes of these funding injections.[76] Efforts to account for gaps have been informed by charity and public health concerns on the part of individual service providers, community healthcare navigators, and small coalitions of practitioners. However, these measures alone may be insufficient to remedy an issue that is subject to fluctuating political discourse and exclusion based on legal status. As such, following sections will address alternative approaches to remedying this issue in the Canadian context.

Legal Approaches to Improving Refugee Healthcare in Canada

The reinstated IFHP, though improved from the years of cuts, fails to ensure in several respects the access of refugees and claimants to high-quality healthcare. While the scope and design

[74] Naseem, *supra* note 5 at 37.

[75] CTV News, "Feds boost health care funding for refugee claimants by $283 million" (27 March 2019), online: *CTV News* <https://www.ctvnews.ca/politics/feds-boost-health-care-funding-for-refugee-claimants-by-283-million-1.4354813>.

[76] Immigration, Refugees and Citizenship Canada, "2020 Annual Report to Parliament on Immigration" by Hon. Marco E.L. Mendicino (Minister of Immigration, Refugees and Citizenship) (2020) online: *Government of Canada* <https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/pub/annual-report-2020-en.pdf>.; Health Canada, "Departmental Plan 2019-2020" by Hon. Ginette Petitpas Taylor (Minister of Health) (2019), online: *Government of Canada* <https://www.canada.ca/content/dam/hc-sc/documents/corporate/transparency/corporate-management-reporting/report-plans-priorities/2019-2020-report-plans-priorities/2019-2020-dp-eng.pdf>.

of the exploratory study is limited, the preliminary results call for the use of multifaceted approaches to improve refugee access to healthcare on a national scale. The OHCHR stated the realization of the "highest attainable standard of health conducive to living a life in dignity" entails the use of several complementary approaches, including the adoption of legal instruments.[77] This section explores the use of legal approaches to strengthen refugee access to healthcare in Canada.

International Commitments to Protect Health

In 1948, the *Universal Declaration of Human Rights* ("UDHR") enshrined the right to health with Article 25 stipulating that "everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."[78] Over half of the written constitutions of the world have constitutionalized this right in enforceable language.[79] The preamble of the *WHO Constitution*[80] and Article 12.1 of the *International Covenant on Economic Social and Cultural Rights*[81] ("ICESCR") affirm a right to "the enjoyment of the highest attainable standard of health" and outline responsibilities for states to progressively implement services to enable physical and mental health.[82] Furthermore, the 1951 Convention emphasizes that refugees should have access to health services equivalent to

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[77] Office of the High Commissioner for Human Rights, "CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health" (11 August 2000), online: *OHCHR* <https://www.refworld.org/pdfid/4538838d0.pdf> at para 1 [*General Comment 14*].

[78] *Universal Declaration of Human Rights*, 10 December 1948, Art 25, online: *UN* <https://www.un.org/en/universal-declaration-human-rights/>.

[79] Matthew M. Kavanagh, "The Right to Health: Institutional Effects of Constitutional Provisions on Health Outcomes" (2016) 51:3 Studies in Comparative International Development 328 at 329.

[80] *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference*, New York, 22 July 1946, WHO (entered into force 7 April 1948).

[81] *International Covenant on Economic, Social and Cultural Rights*, 19 December 1966, GA Resolution 2200A (XXI) Article 12 (entered into force 3 January 1976).

[82] This does not entail an unconditional right to be healthy. See Office of the High Commissioner for Human Rights, "The Right to Health: Fact Sheet No.31" (June 2008) at 5, 29, online: *OHCHR* <https://www.ohchr.org/documents/publications/factsheet31.pdf> [*Right to Health Fact Sheet*].

that of the host population.[83] States have a strict duty to respect this right for all, 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" in addition to abstaining from "enforcing discriminatory practices as a State policy."[84]

While over seventy states including Canada are signatories to the ICESCR, notably fewer have ratified it as binding domestic law.[85] These international legal instruments inform domestic refugee policy but cannot form the basis of cause of action in Canadian courts given an absence of their direct incorporation into domestic law.[86] Canada's approval of these agreements seems limited and an insufficient basis to ground healthcare provision to refugees. The federal government's sixth periodic report to the Committee on Economic and Social Rights for 2005-2009 contained no express mention of initiatives to provide for refugee health pursuant to article 12 of the ICESCR.[87] While women, minorities and varying vulnerable groups were addressed in Canada's 2020 Social Progress Index, noncitizens such as refugees were notably absent from the analysis.[88] The scorecard suggests that for a country of advanced economic status, the needs and interests of refugees is secondary to those of its citizens. Refugees and claimants continue to experience restricted and inequitable access to health services in Canada. These assessments suggest Canadian government's commitment to international human rights covenants has a limited, symbolic effect on refugee healthcare policies.

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[83] *Convention*, *supra* note 20.
[84] *General Comment 14*, *supra* note 77 at para 34.
[85] Jesse Beatson, "The Stories We Tell about Refugee Claimants: Contested Frames for the Health-Care Access Question in Canada" (2016) 32:3 Refuge: Canada's Journal on Refugees 125 at 131.
[86] Michelle Giroux & Mariana De Lorenzi, "Putting the Child First: A Necessary Step in the Recognition of the Right to Identity" (2011) 27:1 Can J Fam L 53 at 87.
[87] Canada, *International Covenant on Economic, Social and Cultural Rights: Sixth Report of Canada* (Minister of Public Works and Government Services of Canada, 2013) at 63, online: *Government of Canada* <https://www.canada.ca/content/dam/pch/documents/services/canada-united-nations-system/reports-united-nations-treaties/pacte_intnl_droits-intnl_covenant_rights-eng.pdf> [*Canada ICESCR Report*].
[88] "2020 Social Progress Index" (2020) online: *Social Progress Imperative* <https://www.socialprogress.org/?tab=2&code=CAN>.

Constitutionalization of a Right to Health

Implementing a right to health, while a potentially beneficial factor, does not necessarily guarantee equitable access to healthcare in many countries. Along with varying interpretations of the "progressive realization" of socioeconomic rights ("SERs") such as a right to health, discrepancies in drafting and constitutional protection complicate the enforceability and realization this right.[89] In Brazil, an individual rights approach to healthcare has allowed those with the means and access to courts to claim costly, non-critical treatments rather than allowing courts to shift resources to fund the best public health interventions.[90] In Columbia, the individualized nature of healthcare claims has raised concerns over excessive litigation and judicial intervention as the only recourse to healthcare access issues.[91] Implementing a right to health can thus have unintended consequences.

South Africa, on the other hand, provides an alternative impact of the right to health, given court rulings have been directed at broader health policy.[92] In South Africa, the Treatment Action Campaign successfully mobilized government procurement of HIV-related medication by using extra-legal tactics like assembling testimonies and organizing a national solidarity response campaign to challenge "unreasonable" government policy.[93] As such, guaranteeing health as a right has rendered mixed results with regards to improving broader health policy and shifting resources to meet public as opposed to private interests. Ultimately, a measure of a nation's commitment to health is largely indicated by three main factors: the public's general attitude toward the enforceability of the constitution, quality of legal

[89] Gunilla Backman et al., "Health Systems and the Right to Health: An Assessment of 194 Countries" (2008) 372:9655 The Lancet 2047 at 2048.
[90] Kavanaugh, *supra* note 79 at 354-355; Keith Syrett, "Evolving the Right to Health: Rethinking the Normative Response to Problems of Judicialization" (2018) 20:1 Health and Human Rights Journal 121 at 124.
[91] Kavanaugh, *supra* note 79 at 351-353.
[92] Maya Gunnarsson, "Constitutionalization of the Right to Health: A Pathway to Improved Health Outcomes?"(26 March 2019), online: *McGill Journal of Law and Health* <https://mjlh.mcgill.ca/2019/03/26/constitutionalization-of-the-right-to-health-a-pathway-to-improved-health-outcomes/>.
[93] Kavanaugh, *supra* note 79 at 350-351.

remedies/access to courts, and scarcity of resources to devote to improving health.[94]

Canada, for one, has chosen not to constitutionalize a right to health, relying instead on other means to ensure access to health services. The CHA and IFHP represent an effort to delineate the duties arising from protection of health as a largely universal benefit. Proponents of constitutional protection of the right to health in Canada suggest that a more expansive reading of s.7 could serve as an alternative to modifying the Charter. Courts oversee compliance of the government to these standards and can compel state actors to compensate for acts or omissions that endanger a patient's right to security, including timely access to care.[95] Given statutory and judicial mechanisms, lack of a constitutionalized right to health may not necessarily undermine access to healthcare in Canada.

The Charter as a Protective Mechanism for Social and Economic Rights

The *Canadian Charter of Rights and Freedoms* does not explicitly enshrine a right to health or reference any of the socioeconomic guarantees articulated in the ICESCR.[96] However, the expansive wording of s.7 which outlines the right to "life, liberty and security of the person," and the equality guarantees of s.15 offer substantive protection of SERs, including universal healthcare.[97] In particular, s.7 has been invoked as a health-based guarantee in several Charter challenges. Furthermore, recognition of disability as a constitutionally prohibited ground of

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[94] Eleanor D Kinney & Brian Alexander Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World" (2004) 37 Cornell Int'l LJ 285 at 287, 296.

[95] Senate of Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, vol 6 *Recommendations for Reform*, (October 2002) at Ch.5 Timely Access to Health Care online: *Senate Canada* <https://sencanada.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm>.

[96] Martha Jackman & Bruce Porter, "Justiciability of Social and Economic Rights in Canada" (2008) Social Rights Jurisprudence: Emerging Trends in Comparative International Law at 2.

[97] *Ibid* at 1. See also *Canadian Charter of Rights and Freedoms*, s 7 & s 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

discrimination under s.15 has reinforced the government's positive obligations to protect SERs.[98]

Nevertheless, a recent jurisprudential trend indicates the Supreme Court of Canada ("SCC") has been hesitant to protect SERs in a similar manner to civil and political rights ("CPRs") (i.e. freedom of expression, religion, etc.). Courts have traditionally distinguished between the two by regarding CPRs as imposing only negative duties (i.e. striking down legislation which disproportionately affects individuals) while SERs encompass positive duties (i.e. ensuring equal access to services and treatment required for health).[99] However, the distinction between positive and negative rights break down as both may require "positive action, are resource dependent, and justiciable."[100] Prior to *Chaoulli*, *Gosselin v. Québec (AG)* opened the possibility of imposing positive obligations on the government to fulfill the basic needs of individuals underscored by s.7 rights.[101] However, in 2005, the SCC reinforced the negative rights paradigm of SERs in *Chaoulli v. Québec (AG)*.[102] Chief Justice McLaughlin, writing for a slim majority, stated the Charter "does not confer a freestanding constitutional right to healthcare."[103]

Despite not imposing any positive obligations on the government, s.7 curtails state interference on the realization of health-related outcomes. In *Canada (AG) v. PHS Community Services Society*, the court upheld an exemption from laws banning possession of controlled substances in a government

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[98] *Ibid* at 2.

[99] International Commission of Jurists, "Courts and the Legal Enforcement of Economic, Social and Cultural Rights" (2008) at 10, online: *Intl Commission of Jurists* <https://www.refworld.org/pdfid/4a7840562.pdf> [*ICJ*].

[100] UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 69th Sess, UN Doc A/69/299 (11 August 2014) at para 7 cited in Ania Kwadrans, "Socio Economic Rights Adjudication in Canada: Can the Minimum Core Help in Adjudicating the Rights to Life and Security of the Person under the Canadian Charter of Rights and Freedoms" (2016) 25:1 Journal of Law and Social Policy 78 at 83.

[101] *Gosselin v Québec (Attorney General)*, [2002] 4 SCR 429, 2002 SCC 84.

[102] Kwadrans, *supra* note 100 at 96. See also Colleen M Flood, "Chaoulli's Legacy for the Future of Canadian Health Care Policy" (2006) 44:2 Osgoode Hall LJ 273 at 275-276.

[103] In *Chaoulli*, the SCC struck down provincial legislation which prohibited access to private health insurance, citing unreasonable life-threatening delays in the public health system which violated the applicant's s.7 right to life. See *Chaoulli v Québec*, [2005] 1 SCR 791, 2005 SCC 35 at para 104.

controlled safe injection facility. Withholding health services on the basis of these laws constituted an infringement on drug users' s.7 rights to security and their lives.[104] As such, s.7 has been construed in a health-protective manner. In addition, the wording of s.15 may encompass a more substantive approach to health equality, including government funding of sign language interpretation for deaf applicants in *Eldridge v. British Columbia (AG)*.[105] The SCC's approach to resource allocation for SERs has included positive measures to ensure equal access to healthcare.[106] On the other hand, *Auton* demonstrated the SCC's narrow interpretation of this approach as non-core medically necessary treatments were not protected under s.15.[107] The Court's dismissal of a s.7 argument post-*Chaoulli* and acceptance of a limited interventionist approach under s.15 illustrates the limitations of addressing health policy issues as a matter of law.[108]

In the context of refugee health, *Canadian Doctors for Refugee Care v. Canada*[109] demonstrated the court's refusal to find that s.7 rights were engaged by denial of necessary healthcare provision to refugees and claimants. While the cuts were overturned, the court reaffirmed that the s.7 right to life on its own imposes no positive obligations on the government to ensure access to healthcare necessary for life.[110] Critics note that reducing a right to healthcare to the right to pay for a right contradicts the very nature of human rights for all.[111] Given Canadian courts' adherence to the negative-positive rights paradigm and narrow interpretation of s.7 and s.15, it is doubtful that the Charter can serve as a core means to improve refugee access to healthcare.

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[104] *Canada (Attorney General) v PHS Community Services Society*, [2011] 3 SCR 134.
[105] Jackman & Porter, *supra* note 96 at 4.
[106] Mel Cousins, "Health Care and Human Rights after Auton and Chaoulli" (2009) 54:4 McGill Law Journal / Revue de droit de McGill 717 at 717.
[107] *Auton (Guardian ad litem of) v British Columbia (AG)*, [2004] 3 SCR 657, 2004 SCC 78.
[108] Cousins, *supra* note 106 at 738. See also *Chaoulli*, *supra* note 101 at para 161.
[109] *CRDC*, *supra* note 57.
[110] Kwadrans, *supra* note 100 at 80.
[111] Kwadrans, *supra* note 100 at 96.

Barriers to the Use of Legal Approaches for Refugees in Canada

Newcomers to Canada face significant barriers to the use of legal approaches which can undermine their efforts to contest healthcare inadequacies. First, the separation of powers doctrine in Canada can limit political compliance and cooperation with court decisions. Refugee healthcare litigation can pose challenges when violations require structural reforms as a remedy, demand budgetary allocations or extend remedial phases which require continuous monitoring.[112] Accordingly, a lack of guarantees to enforce judicial orders targeting political branches combined with insufficient judicial power to influence budgetary allocations are significant issues to refugee healthcare litigation.[113]

Second, framing healthcare access within the constraints of a legal framework fails to capture the full extent of SERs violations, envisioning them as mere legal "problems" remedied by court orders as "solutions."[114] Furthermore, traditional litigation emphasizes time and resource allocation at the trial stage while the development and implementation of remedies receives less attention.[115] States also retain significant procedural advantages over individuals given ample economic and administrative resources at its disposal. As well, court decisions do not always translate into significant material change.[116]

For refugees, additional barriers include: lack of familiarity with the Canadian legal system and society, limited or no knowledge of English or French, poverty, poor physical or mental health as a result of trauma, and experiences in a country of origin with precarious institutions and infrastructure.[117] Fear of the legal system coupled with cultural dissonance and previous experiences of embodied vulnerability at a refugee determination hearing can

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[112] *ICJ*, *supra* note 99 at 89.
[113] *Ibid* at 91.
[114] Orly Lobel, "The Paradox of Extralegal Activism: Critical Legal Consciousness and Transformative Politics" (2007) 120:4 Harv L Rev 937 at 950-951.
[115] *ICJ*, *supra* note 99 at 94.
[116] Lobel, *supra* note 114 at 954.
[117] Jennifer Bond & David Wiseman, "Imperfect Evidence and Uncertain Justice: An Exploratory Study of Access to Justice Issues in Canada's Asylum System" (2020) 53:1 UBC L Rev 1 at 14.

further dissuade refugees from seeking just health outcomes.[118] One study on the refugee determination process noted that adjudicators had difficulty addressing evidence related to the cultural and psychological context of refugee claims. Canada-centric laws applied in assessing the credibility of claimants[119] combined with racial and cultural differences could contribute to a risk of inequality and unfairness in the judgements rendered. Similar difficulties may surface when litigation is pursued in the context of refugee healthcare.

Litigation consumes individuals with vast resource demands and can detract attention from alternative avenues of reform.[120] Legal enforcement is often construed as backward looking or retroactive, focusing on past wrongs while failing to deter future wrongdoing or sustain advocacy efforts.[121] Instead, law can be used as part of a larger organizing campaign not to simply win a lawsuit or obtain compensation but to put pressure on the State.[122] Legal advocacy can be intimately joined and subordinate to grassroots organizing campaigns that can lead to positive social change. Legal scholar Shin Imai expands on the concept of social justice lawyering whereby lawyers shed the role of expert and savior and attune themselves to the needs of the community through in-depth participation of community members.[123] Relying on legal methods to elicit transformative social change risks exclusion of community voice and persistence of health care injustices.[124] Ultimately, the question remains, how do we begin to produce an advocacy framework that is truly relevant and meaningful for refugees in Canada?

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[118] Canadian Bar Association, "Reaching Equal Justice Report: An Invitation to Envision and Act" (2013) at 14, online: *CBA* <https://www.cba.org/CBAMediaLibrary/cba_na/images/Equal%20Justice%20-%20Microsite/PDFs/EqualJusticeFinalReport-eng.pdf>. See also Olsen, *supra* note 24 at 64.

[119] Bond, *supra* note 117 at 14.

[120] Lobel, *supra* note 114 at 949.

[121] Lobel, *ibid* at 954.

[122] Miguéz, *supra* note 9 at 26 citing Lobel, *ibid* at 961.

[123] Miguéz, *supra* note 9 at 26 citing Shin Imai, "A Counter-Pedagogy for Social Justice: Core Skills for Community-Based Lawyering" (2002) 9.1 Clinical Law Review 195 at 195, 201-204.

[124] Miguéz, *supra* note 9 at 26-27.

Alternative Methods: Building Capabilities & Leveraging Community Voices

The Case for Community Voice

Upon reinstatement of the IFHP in 2016, Hon. John McCallum, then Minister of Immigration, Refugees and Citizenship declared that "Canadians from many walks of life from premiers to front to line health care professionals…spoke with one voice in rejecting the changes made to the IFHP in 2012. We have listened and coverage will be restored."[125] Notably, recognition of refugee voices was absent from this Canadian-centric statement, signaling a disconnect in the discourse that purported to prioritize refugee needs and interests, at the very least from a "moral minimum" standpoint.[126] Given their legal and social identities exist in a protracted state of limbo, refugees lack civic belonging and benefits of membership in the host society. It is perhaps no surprise that refugees' political voices are diminished, even silenced.[127] One author noted that "feeling unheard or unable to express one's voice is pervasive in the struggles of marginalized people."[128]

At the international stage, the WHO and UNHCR stress the importance of participation and community engagement at both local and national levels of governance.[129] UN General Comment No.14 asserts that the formulation and implementation of national health strategies "must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health."[130] Health policy reform hinges on the ability of individuals to engage in decision-making processes which directly impact their development. However, while the federal government has made

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[125] "Restoring Fairness to the Interim Federal Health Program" (2016) online: *Canada.ca* <https://www.canada.ca/en/immigration-refugees-citizenship/news/2016/02/restoring-fairness-to-the-interim-federal-health-program.html>.
[126] Beatson, *supra note* 85 at 126.
[127] *Ibid*.
[128] Will Jones, "Refugee Voices" (2019) at 2, *World Refugee Council Research Paper No.8* online: *<https://www.cigionline.org/sites/default/files/documents/WRC%20Research%20Paper%20no.8_1.pdf>*.
[129] *Right to Health Fact Sheet*, *supra* note 82 at 4.
[130] *General Comment 14*, *supra* note 77 at para 54.

strides towards inclusion of community-based approaches to strengthen First Nations' access to equitable care, no similar commitment has been affirmed in the context of refugee health.[131]

Participatory Action Research: A Salient Solution?

The inclusion of refugee voices can have concrete, transformative effects on policies directly affecting them.[132] In particular, the Participatory Action Research ("PAR") framework provides this necessary space for "collective voice, action and dialogue."[133] A PAR approach centers on refugee voices and leverages their insights and abilities to resolve salient issues.[134] PAR requires equal participation of both the researcher and participant, taking into consideration relations of authority and power at each stage of the process. The goal is one of partnership and collective discovery through mutual trust and transparency. The researcher and participants take on the role of both experts and learners through self-reflexive dialogue.[135] Dialogue allows for the reframing of dominant discourse to reflect multiple perspectives stemming from social location, race, gender, education and citizenship. Expanding on the PAR approach, post-colonial theoretical perspectives can further be incorporated to critically examine "everyday experiences of marginalization" structured by political, socio-economic, historical and cultural forces.[136] Such an approach examines how systemic practices and structural barriers in a host society suppress refugee resistance and empowerment.[137] Taken together, the PAR/post-colonial approach explores how policies like IFHP essentialize refugees and ultimately affect their health and access to equitable and quality care.

However, there exists challenges to a purely participatory framework that aims to promote refugee healthcare access. The

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[131] *Canada ICESCR Report*, *supra* note 87 at 69.
[132] Sepali Guruge & Nazilla Khanlou, "Intersectionalities of influence: researching the health of immigrant and refugee women" (2004) 36:3 Canadian Journal of Nursing Research Archive at 35.
[133] *Ibid* at 40.
[134] Jeannette van der Velde, Deanna L. Williamson, and Linda D. Ogilvie, "Participatory action research: Practical strategies for actively engaging and maintaining participation in immigrant and refugee communities" (2009) 19:9 Qualitative Health Research 1293 at 1294.
[135] Guruge & Khanlou, *supra* note 132 at 39.
[136] *Ibid* at 35.
[137] *Ibid* at 36-37.

inclusion of refugee voices can be performed in a tokenistic manner whereby the most heartbreaking or inspirational stories are seen as emblematic of a diverse and pluralistic population.[138] Non-governmental organizations and international refugee agencies can sometimes curate refugee voices to convince host societies (generally in the global North) that refugees are "like them," "deserving" of protection and sufficiently useful to the society in the future.[139] Formulating refugee voices to fulfill Western ideals of saviorism and utility can be counterproductive and perpetuate victimization of refugees. Advocacy-based approaches informed by refugee voices are thus a double-edged sword. Some suggest that a rights-based discourse[140] can truly empower disenfranchised individuals by allowing them to act on their own behalf.

The Capability Approach and Legal Empowerment: A Way Forward?

The Capability Approach

A significant gap exists between the *de jure* guarantee of refugee' rights at the policy level and the *de facto* realization of these rights on the ground.[141] Asserting health rights claims for refugees and refugee claimants can impose a controversial obligation and positive duty on host societies to provide care for non-citizens.[142] A rights-based approach is perhaps less intuitive to healthcare professionals who frame healthcare access for claimants in terms of their moral worthiness and victimhood.[143]

However, the capability approach[144] developed by Amartya Sen and Martha Nussbaum may remedy some of the

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[138] Jones, *supra* note 128 at 1-2.
[139] *Ibid*. See also Beatson, *supra* note 85 at 129-131.
[140] Beatson, *supra* note 85 at 130-132.
[141] Magnus Manhart, *Capability and Legal Empowerment for escaping the 'Refugee Warehouse' - an assessment of the Global Compact on Refugees and the Comprehensive Refugee Response Framework in Kenya* (Master's Thesis, McGill University Faculty of Law, 2019) [unpublished] at 32.
[142] Beatson, *supra* note 85 at 131 citing Cécile Rousseau et al., "Health care access for refugees and immigrants with precarious status" (2008) 99:4 Canadian Journal of Public Health 290-292.
[143] Beatson, *supra* note 85 at 131.
[144] Amartya Sen defines the idea of 'capability' as "the opportunity to achieve valuable combinations of human functionings – what a person is able to do or

challenges to a rights-based framework. This comprehensive approach focuses on positive freedoms and an individual's capacity to effect change in their circumstances as opposed to merely preserving negative freedoms (i.e. absence of state interference).[145] Sen's theory emphasizes human development through capability expansion which is the process of "expanding the real freedoms that people enjoy."[146] For instance, an individual may not eat due a severe scarcity of food or an individual may choose to fast despite an abundance of food. The latter exercises a capability to choose to fast while the former is denied both the opportunity and ability to choose.[147] Capability reflects the ability of individuals to exercise agency on their own terms and values, regardless of external pressures.[148] This approach to well-being relates to a person's freedom to choose between different ways of living.

Situations of refugees in Canada are akin to those living in poverty, which Sen understands as a deprivation of capabilities and basic opportunities.[149] Refugees can be denied agency and voice in the processes that dictate their lives. The term "refugee" is itself a purely legal label that overlooks their humanity and right to an adequate standard of living. Accordingly, the capability approach steps away from the legal discourse of refugees with the aim of seeing refugees as humans first (and their status second) with a focus on restoring their dignity. An emphasis on building capabilities can give refugees the voice and mechanisms

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be." See Amartya Sen, "Human rights and capabilities" (2005) 6:2 Journal of Human Development 151 at 153.

[145] Manhart, *supra* note 141 at 24 citing Irene van Staveren & Des Gasper, "Development as freedom: contributions and shortcomings of Amartya Sen's development philosophy for feminist economics" (2002) International Institute of Social Studies of Erasmus University Rotterdam at 2–3.

[146] Manhart, *supra* note 141 at 24, citing Amartya Sen, *Development as freedom*, 1. ed., 6th print ed (New York: Knopf, 2001) at 23; Ingrid Robeyns, "The Capability Approach" (2016) online: *The Stanford Encyclopedia of Philosophy* <https://plato.stanford.edu/archives/win2016/entries/capability-approach/>.

[147] Manhart, *supra* note 141 at 22 citing David A Clark, "The Capability Approach: Its Development, Critiques and Recent Advances" (2005) at 5, online: *Global Poverty Research Group* <https://ora.ox.ac.uk/objects/uuid:5b8a1858-c28f-47c0-9a6e-465358893a01/download_file?file_format=pdf&safe_filename=gprg-wps-032.pdf&type_of_work=Working+paper>.

[148] Manhart, *supra* note 141 at 25 citing Amartya Sen, *Development as Freedom*, 1. ed., 6th print ed (New York: Knopf, 2001) at 44-45.

[149] Manhart, *supra* note 141 at 31.

to make decisions about their own lives and participate in the processes that directly affect them.[150] Rather than adopting a central list of capabilities which Sen opposes, the next sections will address the capabilities necessary to enable meaningful participation and empowerment of refugees.

Legal Empowerment

Legal empowerment ("LE") is key to translating refugees' needs into rights. LE hinges on the normative force of the law which is based on the principle that every individual within a state, regardless of citizenship status, is equal before and subject to the law. The rule of law and the justice system can thus have an equalizing effect by regulating power while allowing the voices of marginalized groups to surface.[151] This is particularly essential for refugees who lack access to political mechanisms of accountability yet still need to claim status, entitlements and a place within the decision-making process. In this vein, Purkey defines legal empowerment as:

> "The process through which protracted refugee populations become able to use the law and legal mechanisms and services to protect and advance their rights and to acquire greater control over their lives, as well as the actual achievement of that increased control."[152]

Legal empowerment is both a process by which refugees can use the law to advance their rights and attain control over decisions that affect their lives. Secondly, law is used as the vehicle for a transfer of power to amplify the voice and claims of those with precarious legal and political positions. Thirdly, it centers on the individual in need of empowerment, with a focus on what the refugees are able to achieve, not what others can achieve on their behalf. Fourthly, it acknowledges that formal legal institutions must be granted to allow refugees to access true justice.[153]

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[150] Anna Lise Purkey, "A Dignified Approach: Legal Empowerment and Justice for Human Rights Violations in Protracted Refugee Situations" (2014) 27:2 Journal of Refugee Studies 260 at 261.
[151] *Ibid* at 264 citing Dan Banik, "Legal Empowerment as a Conceptual and Operational Tool in Poverty Eradication" (2009) 1:1 Hague Journal on the Rule of Law 117-131.
[152] Purkey, *supra* note 150 at 265.
[153] *Ibid*.

Capabilities for Legal Empowerment

This section enumerates several capabilities that may be helpful to empower refugees in protracted situations of healthcare deprivation.

i) Health security

Health security is a precondition for legal empowerment. Host societies rely on the notion of the individual as a self-sustaining entity. Constraining access to healthcare endangers refugees' membership in society because it prevents them from being truly engaged and working members within host societies. Sen and Nussbaum acknowledge that health is a prerequisite to become legally enabled as basic capability relating to "freedom from fear and freedom from want."[154] Framing refugees as rights-holders and entitled to a life of dignity can bolster access to healthcare and further justice.

ii) Knowledge and Access to Information

Education and training are central tenants to legal empowerment and capacity-building. Refugees must gain knowledge and information on their rights (i.e. entitlement to healthcare access), relevant laws, and mechanisms through which claims can be asserted and disputes resolved.[155] In Section II, the research findings reveal that refugees repeatedly expressed what little knowledge they had of how the healthcare system functions or how to claim entitlements. Knowledge must translate into action. This can be facilitated by providing legal assistance and counsel directly to refugees to enable them to navigate both the healthcare and justice systems. With adequate education, refugees can acquire the necessary paralegal skills to defend the rights of their peers and assist with translation, training sessions on human rights, and navigation of the healthcare and justice systems.[156] Refugee paralegals have the social and cultural competencies to help dismantle barriers particular to refugee

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[154] United Nations Development Programme, *Human Development Report 1994* (UN, 1994) at 24.
[155] Purkey, *supra* note 150 at 268.
[156] Manhart, *supra* note 141 at 41 citing Tshimankinda Christian Musenga, "Refugee paralegals | Forced Migration Review" online: *Forced Migration Review* <https://www.fmreview.org/economies/musenga>.

communities. They can also ensure sustainability of access to justice in the absence of external aid.[157]

iii) Leveraging Refugee Voices

Enabling refugees' voices to surface in the policy making process should be a key component of the federal government's approach to improving refugee healthcare. A first step in this direction may entail incorporating refugee input within the refugee status determination process. Discriminatory practices and inconsistencies can surface within this process when a panel of judges try to ascertain the validity of a refugee claimant's oral testimony, and whether the claimant can qualify as a refugee under the Convention. Consulting refugees may help remedy procedural inequities that arise from varied information and testimonies regarding countries of origins.[158] Regularizing refugee voices within this ubiquitous process can open the door to further engagement of refugees at the level of health policy reform.

iv) Rights-Based Advocacy and Accountability

Thus far, the Canadian approach to refugee healthcare has been steeped in a brand of humanitarianism historically centered on meeting the immediate needs of refugees, rather than their long-term rights. Needs-based approaches attract the funding and generate more immediate results than long-term approaches aimed at realizing refugees' capabilities and rights.[159] However, needs-based approaches risk rendering refugees voiceless and reliant on the empathy and compassion of healthcare professionals to obtain vital care. Framing refugees as rights-holders can ground access to care in the face of wavering public sentiment.[160] Healthcare framed as an obligation rather than charity can fundamentally affirm the common humanity of refugees regardless of their legal status.

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[157] Purkey, *supra* note 150 at 268.
[158] Manhart, *supra* note 141 at 43.
[159] Purkey, *supra* note 150 at 263 citing Elizabeth Ferris, "Protracted Refugee Situations, Human Rights and Civil Society" in Loescher, G., Milner, J., Newman, E. and Troeller, G. G. (eds) *Protracted Refugee Situations: Political, Human Rights and Security Implications* (Tokyo: United Nations University Press, 2008) at 85–107.
[160] Beatson, *supra* note 85 at 132.

In reality, provision of healthcare to refugees is largely determined by budget and policy constraints with little emphasis on their rights. Accountability entails that states and decision makers are held responsible to stakeholders regarding the exercise of their powers. Given refugees do not have access to traditional political processes of accountability (i.e. elections), they must employ alternative measures to put pressure on the host state.[161] These may take the form of such as reporting on the state of human rights, engaging in grassroots advocacy for policy reform, and facilitating consultation with decision makers. A rights-based approach provides refugees with access to the language of rights-holders and duty-bearers which in turn enables these individuals to demand accountability for the respect and fulfillment of human rights obligations. This kind of accountability is owed by those who exercise significant power over the lives of marginalized individuals.[162]

Concluding Recommendation

Upon arrival into Canada, refugees and claimants face hindered access to healthcare and a system burdened with a legacy of exclusion and structural discrimination. With their legal status in limbo, refugees face additional barriers to having their humanity recognized and achieving an adequate standard of living. Experiences of deprivation, physical or psychological trauma, and displacement among other factors can render this population susceptible to poor health outcomes. Canada prides itself in values of equity and universal healthcare, yet fluctuating political discourse and Othering of refugees through restrictive health policy undermine the promotion of human rights for all within its borders. Purely legal approaches to remedying access to healthcare risk disempowering refugees and posing additional structural barriers for them to contend with for their wellbeing. To circumvent these barriers, approaches must leverage the voices and capabilities of refugees themselves to promote sustainable health policy reform.

Incorporating the needs and priorities of stakeholders forms the vital basis of a human-rights based approach aimed at remedying the issue of access to care. Refugee community members and service providers provide rich perspectives

[161] Purkey, *supra* note 150 at 269.
[162] *Ibid* at 270.

informed by their lived experiences under the current healthcare regime. The IFHP exploratory study, performed at the Centre for Health Policy and Ethics at the University of Ottawa, revealed concrete proposals from stakeholders such as increasing the accessibility of informational materials, ensuring the support of refugee clients navigating the system, and educating service providers on their obligations. In this regard, Canada could benefit from following the example of its international counterparts. For instance, in Sweden, migrants are encouraged to share common problems encountered when navigating the healthcare system and are regularly educated on their rights and entitlements. Training initiatives in Germany are aimed at improving the knowledge and responsiveness of health providers to migrants' specific needs with an emphasis on mental health, cultural diversities and conflict mediation.[163] In the context of the study, IFHP stakeholders also recognized the need for community-focused strategies such as implementing know-your-rights training sessions and increasing coverage for interpreters. Interviewees emphasized expansion of IFHP coverage to ensure preventative care and echoed previous calls for increased access to mental health services.[164] While further research is required, the depth of insights rendered from the study point to the significance of employing community-informed methods to influence policy development.[165]

In closing, this paper argues that a broad, multi-faceted approach is vital to improve refugees' and refugee claimants' access to healthcare in Canada. This paper recommends that refugee health policy reform must implement participatory methods that harness community voices and pay heed to their perspectives and needs. Furthermore, a rights-based approach to advocacy can allow refugees to regain agency in the processes that directly affect them while overcoming barriers to the use of purely legal approaches. Ultimately, enhancing education and building capabilities are essential to empowering this population to challenge the conditions of their treatment and defend their dignity.

[163] OECD, *supra* note 17 at 4, 6.
[164] Chen et al., *supra* note 41 at 100.
[165] Miguéz, *supra* note 9 at 32.

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